Équipe de santé familiale communautaire de l'Est d'Ottawa

Équipe de santé familiale

REQUEST FOR MENTAL HEALTH SERVICES

Date: _____

Patient's Name: _____

Date of Birth: _____

Location where you see your doctor/nurse practitioner: ☐ Orléans ☐ Overbrook

Please describe the main reason you are seeking help:			
What are your goals? What do you need help changing?			
What are you currently doing to cope with this situation?			
Do you have support from family or friends?			
☐ Yes ☐ No			
Have you received mental health services in the past? (Check all applicable answers.)			
☐ No ☐ Yes: ☐ Here ☐ Elsewhere			
Availability for phone call:	☐ Morning	☐ Afternoon	☐ Evening
Best phone number to reach you at:			
Permission to leave you a phone message:	☐ Yes	☐ No	

THIS INFORMATION CONSIDERED CONFIDENTIAL.

For clinic staff only:

_____ _____

Date received: Initials: