
Referral to the Mental Health and Addictions Peer Support Program (MAPS)

Client Contact Information:

First Name

Last Name

Preferred Name

Phone Number (Permission to leave messages)

Date of Birth: DD MM YYYY

(Permission to Text)

Preferred method to be contacted:

Email

Phone

Text

Email Address (Permission to email)

Address

City

Postal Code

Is there a Mental Health Diagnosis: Yes No Comments: _____

Is there a Physical Health Diagnosis Yes No Comments: _____

Addiction Supports Required Yes No Comments: _____

Additional Comments:

Please contact us if you have any further questions or visit us online. The MAPS Peer support Specialist will contact the referring individual to assess the referral and begin to develop a care plan

for the individual.



Referral Source Contact Information (Must be included):

Probation or Parole Contact: _____

Phone Number: _____ Extension: _____ Fax: _____

Reason for referral:

Is client aware of the referral and in agreement to attend this program?

- YES
 NO

Does client have access to internet and/or data?

- YES
 NO

Does the client have one of the following for virtual visits?

- Smart Phone
 Tablet
 Computer

Does client require additional support or training on how to connect for virtual appointments/ courses?

- YES
 NO

I consent for my PO to speak about the Mental Health and Addictions Peer Support Specialist

- YES
 NO

What needs do you think the client has?

Please complete this referral form and fax to 905-436-9561

Please contact us if you have any further questions or visit us online. The MAPS Peer support Specialist will contact the referring individual to assess the referral and begin to develop a care plan

for the individual.

