



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

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for the individual.

