Canadian Mental Health Association
Niagara
Mental health for all

Canadian Mental Health Association, Niagara Branch

Short Term Residential Crisis Support Program (Safe Beds)
15 Wellington Street
Referral Form

Please fax this information to: 905-641-8821 upon referral

The CMHA Short Term Residential Crisis Support Program (Safe Beds) is part of the network of mental health services in the Niagara Region. The Safe Bed Program provides crisis counselling, short term goal setting, assistance with coping strategies, symptom management information and referrals. It offers a safe therapeutic environment for males and females to stay for a short term as an alternative to hospitalization. There are 7 Safe Beds located in St. Catharines that can be accessed by individuals from across the Niagara Region when referred to the program. Referrals are accepted from therapists, counsellors, physicians, nurses, social workers, crisis workers and any other professionals with a working knowledge of the individual's current situation and relevant history. Eligibility criteria include: 16 years of age and older, agreeable to the service, maintain sobriety for entirely of stay, self-identified mental health crisis with or without a diagnosis, does not pose a health and safety risk.

Please complete this referral form in detail for referrals you wish to make to our program. You will need to provide a phone number Safe Bed Staff can call you back at if more information is required and to notify you if the client has been accepted into service. A decision will be made regarding appropriateness for the program fairly quickly following the receipt of this completed referral form.

Date: _____ **Time:** _____

Referral Source Name: _____ **Phone Number:** _____

Has client consented to be referred to our services? **Yes** **No**

Client Name: _____

Date of Birth: _____ **Identified Gender** _____ **or** ☐ **Prefer not to answer**

Current Address _____ **City** _____ **Postal Code** ___ ___

Telephone _____ **(Alternative phone/contact)** _____ **No phone** _____

Family Doctor _____ **Date of last visit** _____

Psychiatrist _____ **Date of last visit** _____

Mental Health Diagnosis (if there is one) _____

Current Symptoms and other concerns (Please check all that apply)

☐ angry, irritable, agitated
☐ anxiety, panic
☐ appetite: increase/decrease
☐ mood changes
☐ current suicidal thoughts
☐ past suicide attempts
☐ relationship/family issues
☐ disorientation
☐ disturbances in thought
☐ weight gain/loss
☐ learning difficulties
☐ money problems
☐ guilt
☐ hallucinations
☐ auditory/visual hallucinations
☐ housing issue
☐ sleep: decrease/increase
☐ changes in memory
☐ energy-increase/decrease
☐ violent or dangerous thoughts
☐ physical disability
☐ paranoia
☐ trouble reading/writing
☐ difficulty with decisions
☐ sadness
☐ self esteem
☐ physical health issue
☐ feelings of hopelessness
☐ substance use: drugs/alcohol

Other symptoms/issues _____

Presenting Issues

_ Housing
_ Problems with Substance Abuse/Addictions.
_ Threat to self/other
_ Mental Health issues
_ Problems with relationships
_ Financial issues
_ Physical/Sexual Abuse issues
_ Daily Activity Living Skills issues
_ Issues related to sexual orientation or gender identity
_ Other _____

Does the individual have a history of substance abuse? Yes No
If so, please provide date of last substance use: _____

Does the individual have a history of self-harm, suicidal ideation/attempts or putting him/herself at risk? If so, please provide more information (i.e. current thoughts, last attempt, risky behaviour, etc) Yes No

_____

_____

Does the client have a history of aggression/violence? Yes No
If so, please provide more information (i.e. current thoughts, last act of aggression, etc.)

_____

_____

Does the client have any current charges or is he on probation? If so, please identify the nature of the charges

_____

_____

What would the client like help with at Safe Beds?

_____

_____

_____

Current Medications

Name of Medication	Dosage	When to take

Has the client been taking these medications regularly? Yes No
If the client has been taking these medications, does he/she have enough? Yes No
Are refills needed? Yes No

Does the client have any medical or mobility issues? Yes No
If so, please explain:

_____

_____

Are there any other special considerations (i.e. accessibility, language, vulnerability, trauma, self care, social issues) Yes No
If so, please explain and indicate what may be required to accommodate these needs:

_____

_____

What other service(s) does the client currently use?

_____

_____

Is there anything else you would like us to know that would help us understand this request for service?

_____

_____

Referral Sources Signature _____ Date _____

This fax contains confidential information, if received in error; please contact 905-641-5222