660 Dundas Street East, Level 3. Unit 4
Toronto, ON M5A 0R3
647-947-6090 (phone)
647-689-2270 (fax)
intake@wanasah.ca

REFERRAL FORM

Referral Date (dd/mm/yyyy): _____/_____/_____

Client Details

First Name: _____ Last Name: _____

Date of Birth (dd/mm/yyyy): _____ Gender: _____

……..

By listing phone numbers and emails, the referral source confirms they have obtained client consent for Wanasah to communicate with them via phone/text and/or email regarding this referral.

Address: _____

Postal Code: _____

Email: _____ _____Phone: _____

Preferred Method of Contact (email, text, phone, etc.): _____

Referral Source

First Name: _____

Last Name: _____

Position: _____

Organization: _____

Address: _____

Phone: _____ Fax: _____

Signature: _____

Parent/Guardian (clients < 16 years)

First Name: _____ Last Name: _____

Relationship to client: _____

Phone: _____ Email: _____

660 Dundas Street East, Level 3. Unit 4
Toronto, ON M5A 0R3
647-947-6090 (phone)
647-689-2270 (fax)
intake@wanasah.ca

Additional Referral Info

Reason for Referral: _____

Please detail any potential safety risk identified for client or staff:

_____

_____

_____

Other pertinent information or details about client to support their care:

_____

_____

_____

Services Requested (Check all that apply)

Mental Health Counselling/Therapy for Youth related to (check all that apply)

- ☐ Substance Use/Addictions
- ☐ Trauma
- ☐ Grief
- ☐ Mood Disorder (Anxiety, Depression, etc.)

Other:

_____

Short Term Case Management for Youth Mental Health Services Navigation

Fax the referral to 647-689-2270

We aim to respond to referral requests within 2 weeks.