



Canadian Mental  
Health Association  
Niagara  
Mental health for all

**Canadian Mental Health Association, Niagara Branch**  
**Short Term Residential Crisis Support Program (Safe Beds)**  
**264 Welland Avenue, Suite 103** (enter from Tasker 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 entirety 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)**

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

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, Yes No  
 please provide more information (i.e. current thoughts, last attempt, risky behaviour, etc) \_\_\_\_\_

**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** \_\_\_\_\_