Canadian Mental Health Association
North Bay and District

Association canadienne pour la santé mentale
North Bay et District

Central Access Referral

CMHA North Bay and District, Central Access Office
176 Main St. West, North Bay ON P1B 2T5
T 705.476.4088 **F** 705.495.3585 **E** CentralAccess@nbd.cmha.ca **W** nbd.cmha.ca

Date (dd/mm/yyyy):_____

Name: _____ DOB (dd/mm/yyyy): _____

Gender: ☐ Male ☐ Female ☐ Other (specify) _____

Address: _____ NFA: ☐ City:_____ Postal Code: _____

Telephone: _____ E-mail address:_____

How would you like us to contact you? ☐ Telephone ☐ E-mail

Do we have permission to leave a voicemail? ☐ Yes ☐ No

Preferred language for service: ☐ English ☐ French ☐ Other: _____

Reason for referral:

Name of person making referral: _____ Agency/Program:_____

Contact information:_____

Permission to contact referring agency/person if needed. ☐ Yes ☐ No

I, _____ am aware and agree with the information provided in this referral for services with CMHA North Bay and District. _____

(Signature of person being referred)

Please Note: A signature from the applicant is required for the referral to be processed. Incomplete referrals will not be processed.