MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

FAMILY SUPPORT GROUP
REFERRAL FORM
(Please note: all information will be kept confidential)

Date:			
Name:	**D.O.B.:**		
Address:	**City:**	**Postal Code:**	
Phone #: (H)	**(Cell)**	**(Work)optional**	
Email:			
Preferred method of contact:			
Is it ok to leave a message:	At home: Y or N	Cell: Y or N	Work: Y or N
Emergency contact #:			
Your Job/School/other:			
How did you hear about our services?:			
Family Member(s) living with mental illness and their diagnosis			
Does your family member live with you?:			
In a few words describe your reason or goals for wanting to attend this group:			
Would you prefer in person or virtual sessions?:			
Best time to reach your for brief phone assessment:			