St. Joseph's Healthcare Hamilton

Schizophrenia & Community Integration Service

Family Education Program for Schizophrenia REFERRAL FORM

FAMILY INFORMATION:

Family Surname:		
Address:		
Telephone:		
Best contact number:		
E-mail:		
Name(s) of family members being referred:	Relation to person with Schizophrenia:	Is planning to attend Family Education Program for Schizophrenia:

Family member availability (check all that apply)

MONDAY	Daytime ☐ Evening ☐	TUESDAY	Daytime ☐ Evening ☐	WEDNESDAY	Daytime ☐ Evening ☐	THURSDAY	Daytime ☐ Evening ☐

Briefly outline reason for referral:

REFERRAL SOURCE:

Name:	
Agency/Unit	Telephone:
Address:	
Present Therapist:	Telephone:
Signature of Referral Source:	Date:

Please contact: Family Education Program for Schizophrenia
100 West 5th Street
Hamilton, ON L8N 3K7
Tel: (905) 522-1155, ext. 39559
Fax: (905) 381-5654