Common Referral Form

WELCOME!

Please ensure that you have completed the accompanying screening tool to ensure that the applicant qualifies for this service.

We want to process this application as quickly as possible (notification of admittance/declined service within 30 days of receipt provided sufficient information is supplied upon first submittal). In order for us to do so, please also answer as many questions as you can in each of the following sections and include as many of the additional support documents as possible requested on the last page.

Please **PRINT** all answers in ink. Should you have any questions or require assistance with filling in this form, please call **(insert number here)** and a staff person will be happy to help you.

Mail or fax the completed application form to the address and fax number below.

Assertive Community Treatment Team
Canadian Mental Health Association
New Liskeard, Ontario, P0J 1P0

Telephone #: 1-705-647-4444 **Fax:** 1-705-647-4434

A/ Personal and Contact information

Applicant:

First Name: _____ Last Name: _____

Street address of discharge: _____

Apt. No: _____ Entry code: _____ Telephone No.: _____ Extension: _____

City: _____ Province: _____ Postal code: _____

If No Fixed Address, Please provide possible location where person might be found: _____

If the applicant does not have a phone or is otherwise difficult to reach, is there someone with whom he or she is in regular contact that we can call in order to reach him or her?

Name: _____ Telephone No.: _____ Extension: _____

Relationship to applicant:_____

Can a message be left at the phone number provided? ☐ Yes ☐ No

Does the applicant have a Substitute Decision-Maker for treatment (SDM)? ☐ Yes ☐ No
If yes, please provide their name, address and contact information:
_____

Does the applicant have a Trustee for finance? ☐ Yes ☐ No
If yes, please provide their name, address and contact information:
_____

Does the applicant have a Power of Attorney? ☐ Yes ☐ No
If yes, please provide their name, address and contact information:
_____

Date of Birth: (mm/dd/yy) _____ **Gender:** ☐ Male ☐ Female ☐ Transgender ☐ Transsexual ☐ Other

Does the applicant have an Ontario Health Card: ☐ Yes ☐ No ☐ Don't know

Ontario Health Card Number (if known): _____

Does the applicant speak English: ☐ Yes ☐ No ☐ Some

What is the applicant's first language(s): ☐ English ☐ French ☐ Other _____

What is the applicant's preferred language: ☐ English ☐ French ☐ Other _____

We are working to ensure that our services are being developed in a manner that serves all the communities living in our boundaries. The following question is voluntary and answering it will not affect the application:

What is the applicant's ethnicity and/or culture (*i.e.* what culture or ethnicity does he/she identify with)?

Culture/Ethnicity: _____ Citizenship/Immigration status: _____

B/ REFERRAL SOURCE INFORMATION *(Please complete if not a self-referral)*

Referrer's name & Title: _____Agency:_____

Telephone # _____ Fax# _____

Street Address: _____ Apt./Suite No.: _____

City: _____ Province: _____ Postal code: _____

Relationship to Applicant:_____

Is the applicant aware of this referral? ☐ Yes ☐ No

Have you completed an Ontario Common Assessment of Need (OCAN) in the past 6 months with the applicant?

☐ Yes ☐ No ☐ Don't know / not sure

C/ CURRENT STATUS

Who does the applicant presently live with? Please check all boxes that apply:

☐ Self ☐ Spouse/partner ☐ Spouse/partner & others
☐ Parents ☐ Relatives ☐ Non-Relatives
☐ Children (Age/Sex) _____

Is the applicant currently homeless or at risk of becoming homeless?

☐ Yes ☐ No ☐ Somewhat If *Yes* or *Somewhat*, please explain: _____

_____

What type of housing does the applicant presently live in?

☐ Approved Homes & Homes for Special Care
☐ Correctional/Probationary Facility
☐ Domiciliary Hospital
☐ General Hospital
☐ Psychiatric Hospital
☐ Other Specialty Hospital
☐ No fixed address
☐ Hostel/Shelter
☐ Long-Term Care Facility/Nursing Home
☐ Municipal Non-Profit Housing
☐ Private House/Apt.- Client Owned /Market Rent
☐ Private House/Apt.- Other/Subsidized
☐ Retirement Home/Senior's Residence
☐ Rooming/Boarding House
☐ Supportive Housing – Congregate Living
☐ Supportive Housing – Assisted Living (RTF 24 Hr Home and Group Homes)
☐ Private Non-Profit Housing
☐ Other_____

What is the applicant's primary source of income?

☐ ODSP
☐ Employment
☐ Pension
☐ Family
☐ CPP/OAS (Old age security) _____
☐ GIS (Guaranteed income supplement)
☐ Social Assistance (*e.g.* Ontario Works)
☐ Employment Insurance
☐ Disability Assistance
☐ No Source of Income
☐ Other _____

What is the applicant's current employment status?

☐ Independent/Competitive ☐ Assisted/Supportive ☐ Alternative Business
☐ Sheltered Workshop ☐ Non-paid Work Experience ☐ No Employment – Other Activity
☐ Casual/Sporadic ☐ No Employment of Any Kind ☐ Unknown or Service Recipient Declined

What is the highest grade/level of education the applicant has attained? _____ What is his/her current education status?

☐ Not in School ☐ Elementary/Junior High School ☐ Secondary/High School ☐ Other
☐ Trade School ☐ Vocational Training Centre ☐ Adult Education
☐ Community College ☐ University ☐ Unknown/Service Recipient Declined

D/ HEALTH INFORMATION

Is the applicant capable to consent to treatment? ☐ Yes ☐ No ☐ Unknown

Is the applicant capable to consent to collection/use/disclosure of PHI? ☐ Yes ☐ No ☐ Unknown

Is the applicant capable to manage property? ☐ Yes ☐ No ☐ Unknown

How long has the applicant been experiencing mental health difficulties (*i.e.* length of time)?

_____

What is the applicant's mental health diagnosis? Please be as specific and detailed as possible.

_____

_____

_____

What was the age of onset of this diagnosis? _____

What was the age of the first hospitalization for mental health reasons? _____

Has the applicant been to hospital (Emergency Room visits and/or in-patient stays) due to mental health challenges in the last two years? ☐ Yes ☐ No ☐ Unknown

Please provide an estimate of the total number of days that they have spent in Hospital In-Patient Units, due to mental health difficulties, within the past two years: _____ days (estimate if need be)

Please list the hospitals the applicant has been in and the dates of the visit:

Hospital	**Day/Month/Year** to **Day/Month/Year**
_____	_____
_____	_____
_____	_____

Is the applicant in hospital now due to mental health issues? ☐ Yes ☐ No

If yes, what is the anticipated date of return to community living?

_____

Is the applicant currently on a Community Treatment Order (CTO)? ☐ Yes ☐ No

Does the applicant have a psychiatrist? ☐ Yes ☐ No

If yes, please provide the following information on the psychiatrist:

Name:_____ Telephone #:_____

Do you have a physician (*e.g.* GP, family doctor, walk-in clinic doctor)? ☐ Yes ☐ No

If yes, please provide the following information on the physician:

Name:_____ Telephone #:_____

Does the applicant have any other illnesses/disability such as:

Concurrent Disorders (substance use and mental illness)	☐ Yes	☐ No	☐ Unknown
Dual Diagnosis (developmental disability and mental illness)	☐ Yes	☐ No	☐ Unknown
Neurological (head/brain Injury, epilepsy, Parkinson's, cognitive disorders etc.)	☐ Yes	☐ No	☐ Unknown
Other chronic illness/ physical disabilities (*e.g.* hypertension, diabetes, allergies)	☐ Yes	☐ No	☐ Unknown

If YES to any of the above, please describe:

_____
_____
_____

Please complete the following list for all current medications being used:

Drug Name	Dose	Start Date	Side Effects Experienced	Comments/Notes:

Please complete the following list for all Mental Health medications used in the past:

Drug Name	Dose	Start/End Date	Side Effects Experienced	Reasons Stopped

E/ APPLICANT'S SUPPORT NEEDS

Applicant is requesting support with:

- ☐ Managing specific symptoms of serious mental health illness
- ☐ Finances
- ☐ Housing needs
- ☐ Substance abuse/addictions issues
- ☐ Legal issues
- ☐ developing daily living skills
- ☐ Educational opportunities
- ☐ Occupational/Employment/Vocation
- ☐ Relationships
- ☐ Social
- ☐ Peer supports
- ☐ Other:_____

_____

_____

Referral source comments regarding the applicant's support needs:

Please briefly describe the reason(s) for referral. What is the present difficulty and in which areas could the applicant benefit from support?

_____
_____
_____
_____

We ask the following questions to determine if there are any safety or risk issues of which we should be aware. Answering any of the questions below *will NOT* exclude the applicant from service. Please include when, how many incidents, how severe and the outcome:

History of self-harm or suicide threats or attempts:

_____
_____
_____

History of substance use or treatment:

_____
_____
_____

History of aggressive behavior or violence (verbal, physical, sexual):

_____
_____
_____

History of destruction of property (including fire-setting):

_____
_____
_____

History of any other risk or safety issue:

_____
_____
_____

Is the applicant currently or has been involved in the past with the criminal justice system? (Please note, this will NOT affect his/her ability to receive service. It is to help us better direct the application)

☐ Yes ☐ No ☐ Don't know

If yes, please indicate dates, types of involvement and outcome:

☐ Bail order
☐ ORB (Ontario Review Board)
☐ Probation
☐ Restraining orders
☐ Parole
☐ Court diversion
☐ Incarcerations
☐ NCR (Not criminally responsible)

Outcome(s):_____
_____
_____

F/ EXISTING SUPPORTS

Is the applicant currently working with any other service providers? ☐ Yes ☐ No ☐ Don't know

If yes, please provide the following information on each service provider with whom the applicant is working:

Agency	Name/Contact Person	Service(s) Received	Telephone Number

Please describe the informal supports (*e.g.* family, friends, faith community, cultural groups/community, other community supports) in the applicant's life and how satisfied they are with each of these supports.

_____
_____
_____

G/ PAST SUPPORTS

Has the applicant worked with any other service providers in the past? ☐ Yes ☐ No ☐ Don't know

If yes, please provide the following information on each service provider with whom they worked:

Agency	Name/Contact Person	Service(s) Received	Telephone Number

H/ SUPPORTING DOCUMENTATION

In order for us to process this referral within 30 days, it is essential that we receive as much of the following documentation as is available to you:

- ☐ Hospital Discharge Summaries (complete history as available)
- ☐ Hospital Documentation (from last 3 months only)
  - Case reviews
  - Nursing notes
  - Treatment plan(s)
- ☐ Specialty and/or specialist assessments (complete history as available)
- ☐ Disposition Orders
- ☐ CTOs (Community Treatment Orders)
- ☐ CPIC (Canadian Police Information Check)
- ☐ ACTT Referral Screening Tool (* mandatory)
- ☐ Related Legal Documentation

APPLICANT AND REFERRER'S DECLARATION & CONSENT

Consent forms allowing communication between the referral source and the Cochrane-Timiskaming ACT Central Intake Service has been included? ☐ Yes ☐ No

I have discussed this referral with the applicant and the applicant agrees with the submission of this referral.

Referrer's signature: _____ Date: _____

***Applicant's signature: _____ Date: _____**

Substitute Decision Maker (SDM) signature: _____Date: _____

*Not necessary to process the application.