**Check only one please :**

- o **Ottawa Assertive Community Treatment Teams**

**OR**

- o **Mental Health Community Support Services**

# REFERRAL FORM

**Date of referral (D/M/Y) :** _____

**SECTION I : Client information**

***1) Demographic data***

Last name : _____ First name : _____ Marital Status : _____

Date of birth (D/M/Y) : _____ Sex : ❑ F ❑ M

Address : _____
_____
_____

Telephone : (_____)_____ Source of income : _____

Language preference : ❑ English ❑ French ❑ Other : _____

Health card # : _____ Social Insurance # : _____

Emergency contact : _____

**SECTION II : Source of referral**

Primary referral source : _____

Agency : _____

Address : _____
_____
_____

Telephone : (_____)_____ Fax : (_____)_____

**SECTION III : Reason for referral**

Explain briefly :

_____

_____

_____

_____

# REFERRAL FORM

**2) Psychiatric diagnosis and health**

Diagnosis : PRIMARY : _____ SECONDARY : _____

Physical problems : _____

**Current medications :**

| NAME | DOSAGE / FREQUENCY |
|---|---|
| | |
| | |
| | |

(Continue on extra sheet if needed)

**3) Hospitalizations (over past 2 years)**

| DATE | DURATION | INSTITUTION |
|---|---|---|
| | | |
| | | |
| | | |

(Continue on extra sheet if needed)

**4) Homelessness**

Dates and duration of homelessness over past 2 years : _____

**5) Substance abuse**

Does the client struggle with substance abuse ? μ Yes μ No

If yes, specify _____

**6) Functional abilities**

| | Yes | No |
|---|---|---|
| Meets basic needs (housing, food)……..…..... | ❍ | ❍ |
| Carries out activities of daily living required for basic functioning in the community (ex. : getting to and from places, medical care, personal hygiene)…….. | ❍ | ❍ |
| Maintains safe housing (no eviction nor loss of housing)…… | ❍ | ❍ |
| Maintains vocational activity (school, volunteering, or employment)……..… | ❍ | ❍ |
| Family and/or social network involvement……...… | ❍ | ❍ |
| History of suicide attempts……...…… | ❍ | ❍ |
| History of harm to others……..… | ❍ | ❍ |
| Has person been declared financially incompetent……..… | ❍ | ❍ |
| Does he/she have a Public Guardian and Trustee…… | ❍ | ❍ |
| Has person been declared incompetent to make treatment decisions……...… | ❍ | ❍ |
| Substitute decision maker (name and relationship)……...… | ❍ | ❍ |

# REFERRAL FORM

**7) Legal**

Dates and duration of incarcerations over past 2 years : _____

_____

Reasons/charges : _____

Other legal problems over past 2 years : _____

Is person under a Community Treatment Order ? μ Yes μ No

Date of issuance : _____ Issuing physician : _____

Has person been declared Not Criminally Responsible ? μ Yes μ No

**8) Other services involved with client :**

| NAME | ADDRESS | PHONE NUMBER |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Has this referral and potential assessment been discussed with :

Client Yes μ μNo
Family Yes μ μNo
Other (specify) : _____

Please include Form 14's signed by client releasing information to ACT Central Intake & MHCSS from referral source and hospitals involved in the past.

*** Please attach information requested below :

1) Discharge summaries of past psychiatric hospitalizations over past 2 years
2) Consultation reports or other significant documents within past 2 years

## N.B. Please note that all incomplete forms will be returned to sender.

S.V.P. Please forward the completed form to the following address :

**For intensive case management (MHCSS)**
c/o Canadian Mental
Health Association
1355 Bank Street, 3rd floor
Ottawa, Ontario K1H 8K7
Telephone : (613) 737-7791
Fax : (613) 737-7644

**For ACT teams**
Lucia Guido
ACT Central Intake Coordinator
900 Merivale Road
Ottawa, Ontario K1Z 5Z8
Telephone : (613) 722-9731
Fax : (613) 722-8244

**If you do not meet criteria for these programs, you will be given suggestions for other mental health resources.**

# Client Consent for Long Term Community Mental Health Support Referrals

The Assertive Community Treatment Teams (ACT) and the Intensive Case Management Services (MHCSS) work in collaboration with each other. To make the process easier for you, we request your permission to discuss your referral at our Joint Monthly meetings. Please sign below giving your consent.

**Date: _____**

**Signature of Client: _____**

**Witness: _____**

**ACT Programs:**

ECTI-Ottawa
Carlington ACT
Ottawa-Carleton ACT
Pinecrest Queensway ACT
Royal Ottawa ACT

**MHCSS- Partners in Case Management**

Canadian Hearing Society
Canadian Mental Health Association, Ottawa
Ottawa Community Care Access Centre
Ottawa Carleton Immigrant Services
Ottawa Chinese Community Services
Ottawa Salus Corporation
Pinecrest Queensway Health & Community Services
Project Upstream
Royal Ottawa Hospital
Somerset West Community Health Centre

I, _____ have reviewed all pages of this Community
(Applicant's Name)
Support Referral Form and I understand that it has been completed as a referral to the central office for Mental Health Community Support Services (MHCSS) located at the Canadian Mental Health Association – Ottawa Branch (CMHA).

I understand that the information contained herein will be shared only with those agencies/ programs that completed the referral on your behalf or with whom you may be referred to for case management follow-up. The organizations noted below are partner agencies with Mental Health Community Support Services to which you may be referred.

Canadian Mental Health Association
Royal Ottawa Hospital
Ottawa Salus Corporation
Project Upstream
Community Care Access Centre
Canadian Hearing Society
Ottawa-Carleton Immigrant Services Organization
Somerset-West Community Health Centre
Pinecrest-Queensway Health Centre
Ottawa Chinese Community Services

_____ _____
Applicant's Signature Date