North Bay Regional Health Centre

Central Intake Referral Form for Community Mental Health Programs

Phone #: 705-476-6240 ext. 6294
Fax #: 705-476-6136

Please note:** ***Incomplete Referrals will result in a delay as they cannot proceed until all information is received

Consent to Referral: ☐ No ☐ Yes	Date: ____/___/____ dd/mm/yy	NB#:
Surname:	First Name:	
HCN: VC:	HCN Expiry Date:	Gender: Female/Male/Non-Binary/Other/Prefer not to say
Primary Language: ☐ English ☐ French ☐ Other		
Date of Birth: ___/____/_____ dd/mm/yy	Marital Status: ☐ Married ☐ Single ☐ Other ___________________	
Address:	City:	Postal Code:
Phone #:	Cell #:	
Referral Source (name and agency):	If External please fill out contact info.	
Address	City	
Postal Code	Phone	Fax
Current Community Supports:		

Primary Care Provider: _____________________ Phone:_________________________________ Fax: __________________________________ ☐ Agreeable to referral	Psychiatrist: ____________________________ Phone:_________________________________ Fax: __________________________________ ☐ Agreeable to referral

Diagnosis if known:

Requested Programs –Please see attached Program Descriptions for full service criteria

☐ **Continuing Care Program** All supportive documentation required ☐ Attached Medication Record ☐ Physician Order for IM administration **please contact us prior to sending the referral to be provided with further supporting supplementary documents required**	☐ **Graduated Group Psychotherapy Program** Are the mental health symptoms ☐ Moderate ☐ Severe ☐ Patient has ongoing support of Primary Care Provider or other community supports. *Service only available for clients residing in the District of Nipissing
☐ **Eating Disorders Program** ☐ Support of by Primary Care Provider ☐ Diagnosis of Anorexia, Bulimia, or Eating Disorder NOS	☐ **Early Intervention and Psychosis Program** ☐ Probable diagnosis of a Primary Psychotic illness not related to Personality Disorder
☐ **Day/Evening Addictions Treatment Program** ☐ Psychiatric stability ☐ Substance Use difficulties ☐ Motivation for change **DAVINCI program offered based on demand and availability**	☐ **Rapid Access Addiction Medicine (RAAM)** ☐ Medical and Psychiatric stability ☐ Primary substance of Alcohol or Opioids ☐ Willingness to use medications ☐ Motivation for change ☐ Please attach most recent metabolic profile and EMR face sheet, if available

☐ Attach current GAIN-SS for all referrals (required document)

History of Presenting Issues (What is occurring in the client’s life leading to the referral?)

Risks

☐ alcohol use ☐ violence towards others ☐ concealing weapons ☐ sexual aggression	☐ drug use ☐ violence towards self ☐ violence towards property ☐ fire-setting	☐ Suicide ☐ Legal Involvement (please specify below) ☐ Falls (if yes, describe any functional mobility/assistive devices)	☐ Other ☐ No Risks identified

Provide relevant details for above:

Please note we are not a crisis or emergency service. Referrals are not prioritized.

If this is an urgent matter, please direct your client to the emergency department at the nearest hospital servicing your client’s community.

Please fax completed referrals to the number listed above.

NBRHC- Out Patient Mental Health Programs Service Descriptors

Community Based Services	**Community Based Programs/Services Outpatient**
Out Patient Mental Health Clinic – Eating Disorders	**Age**: Children Youth (9-17) and Adults (18+) **Service Area**: District of Nipissing **Referrals Accepted from**: Primary Care providers, schedule 1 facilities and community agencies **Type of Service**: Provides individual time limited therapy for youth and time limited group therapy for adults. Offers consultation and education for patients and family members as well as community and hospital programs. **Inclusionary Criteria:** Support of Primary Care Provider; diagnosis of anorexia, bulimia or eating disorder NOS.
Out Patient Mental Health Clinic- Therapy Services	**Age: 16 +** **Service Area**: District of Nipissing **Referrals Accepted from**: Primary Care Providers, schedule 1 facilities; community agencies **Type of Service**: Provides time limited evidence based group psychotherapy using CBT and DBT applied approaches with a specialty in mood and anxiety disorders to enhance recovery and wellness. **Inclusionary Criteria:** Clients living with moderate to severe mental illness with stable basic needs. Clients must be followed by a primary care provider or other service provider.
Outpatient Day/Evening Treatment – Therapy Services	**Age: 16 +** **Service Area:** District of Nipissing and Temiskaming District **Referrals Accepted from**: Self-Referral, Primary Care providers, schedule 1 facilities and community agencies **Type of Service**: Provides 4-16 weeks of blended group and individual psychotherapeutic programming, for those who are seeking to address concurrent substance use and mental health issues. Treatment will focus on a Harm Reduction, with a Trauma-informed approach to care. Persons using Opiate Replacement or Anti-Craving medication are welcome. **Inclusionary Criteria:** Substance use; mental health; psychiatric stability;
Out Patient Mental Health Clinic - Continuing Care	**Age**: **16+** **Service Area**: District of Nipissing **Referrals Accepted from**: Schedule 1 facilities and community agencies **Type of Service**: Ongoing preventative health care support and metabolic monitoring for individuals who continue to require long-term treatment. **Inclusionary Criteria:** Living with a moderate to severe mental illness who have received psychiatric services and are now stable on a regular prescribed antipsychotic medication; are likely to require long-term and ongoing follow-up and do not have an alternate access to medical care.
	Age: 16-35 **Service area:** District of Nipissing **Referral accepted from:** Community, Primary Care Providers

Out Patient Mental Health Clinic - Early Intervention and Psychosis	**Type of service:** The Early Intervention for Psychosis Program provides close psychiatric follow-up, intensive support services and education to individuals experiencing a first episode of psychosis. We also provide support and education to their families. This service is geared towards patients with a probable diagnosis of a Primary Psychotic Disorder and may not accept patients where the psychotic symptoms are secondary to underlying Personality Disorders or if the patients suffers from a significant Developmental Disability.
Out Patient Mental Health Clinic - DAVINCI	**Age: 18** **Service Area:** Districts of Nipissing, Temiskaming- and a portion of the Muskoka/Parry Sound District **Referrals Accepted from:** Primary Care Provider. **Type of Service:** The DAVINCI service is a 16-week outpatient pathway for patients suffering from both Alcohol Use Disorder and Major Depressive Episode. The pathway consists of close psychiatric monitoring with initiation of both anti-craving and antidepressant medications, as well as weekly psychotherapy in an individual format.
Rapid Access Addiction Medicine Clinic -RAAM	**Age: 16+** **Service Area:** District of Nipissing **Referrals Accepted from:** Self-Referral (including walk-in), Primary Care providers, schedule 1 facilities and community agencies **Type of Service:** The RAAM clinic is a time-limited addiction support program for those individuals who are medically stable with primary substances of use are Opioids or Alcohol. RAAM combines addiction medicine (physicians who specialize in addiction) with psychosocial support (assessment, treatment, brief support, case management and referral). Once a treatment plan is implemented, typically in 1-3 visits, patients are referred back to primary care providers and other supportive programs.

To be filled out by the interviewer		
Client Name: a. ____________________	b. __	**c.** ____________________
(First name)	**(M.I.)**	**(Last name)**

Date: |__|__| / |__|__| / 20 |__|__| (MM/DD/YYYY)

GAIN Short Screener (GAIN-SS)

Version [GVER]: GAIN-SS ver. 3.0.1 CAMH

The following questions are about common psychological, behavioural, and personal problems. These problems are considered **significant** when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following questions, please tell us the last time, **if ever**, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

		Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
IDScr 1.	**When was the last time** that you had **significant** problems with…					
	a. feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?.....	4	3	2	1	0
	b. sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?....	4	3	2	1	0
	c. feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?....	4	3	2	1	0
	d. becoming very distressed and upset when something reminded you of the past?.....	4	3	2	1	0
	e. thinking about ending your life or committing suicide?....	4	3	2	1	0
	f. seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?....	4	3	2	1	0
EDScr 2.	**When was the last time** that you did the following things **two or more times**?					
	a. Lied or conned to get things you wanted or to avoid having to do something.......	4	3	2	1	0
	b. Had a hard time paying attention at school, work, or home.	4	3	2	1	0
	c. Had a hard time listening to instructions at school, work, or home.	4	3	2	1	0
	d. Had a hard time waiting for your turn.	4	3	2	1	0
	e. Were a bully or threatened other people.....	4	3	2	1	0
	f. Started physical fights with other people	4	3	2	1	0
	g. Tried to win back your gambling losses by going back another day.	4	3	2	1	0
SDScr 3.	**When was the last time** that…					
	a. you used alcohol or other drugs weekly or more often?....	4	3	2	1	0
	b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g., feeling sick)?....	4	3	2	1	0
	c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?..........	4	3	2	1	0
	d. your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events?....	4	3	2	1	0
	e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?....	4	3	2	1	0

(Continued) After each of the following questions, please tell us the last time, **if ever**, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

CVScr 4. **When was the last time** that you…

a. had a disagreement in which you pushed, grabbed, or shoved someone?	4	3	2	1	0
b. took something from a store without paying for it?	4	3	2	1	0
c. sold, distributed, or helped to make illegal drugs?	4	3	2	1	0
d. drove a vehicle while under the influence of alcohol or illegal drugs?	4	3	2	1	0
e. purposely damaged or destroyed property that did not belong to you?	4	3	2	1	0

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Additional questions (CAMH modified)

After each of the following questions, please tell us the last time, **if ever**, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

AQ5. **When was the last time** you had **significant** problems with… **(not related to alcohol/drug use)**

a. missing meals or throwing up much of what you did eat to control your weight?	4	3	2	1	0
b. eating binges or times when you ate a very large amount of food within a short period of time and then felt guilty?	4	3	2	1	0
c. being disturbed by memories or dreams of distressing things from the past that you did, saw, or had happen to you?	4	3	2	1	0
d. thinking or feeling that people are watching you, following you, or out to get you?	4	3	2	1	0
e. videogame playing or internet use that caused you to give up, reduce, or have problems with important activities or people of work, school, home or social events?	4	3	2	1	0
f. gambling that caused you to give up, reduce, or have problems with important activities or people at work, school, home, or social events?	4	3	2	1	0

	Yes	No
5. Do you have other **significant** psychological, behavioural, or personal problems that you want treatment for or help with? (If yes, please describe below)	1	0

v1. ____

____

6. What is your gender? (If other, please describe below) 1 - Male 2 - Female 99 - Other

v1. ____

7. How old are you today? |__|__| Age

7a. How many minutes did it take you to complete this survey? |__|__|__| Minutes

Staff Use Only

8. Site ID: ______________________ Site name v. ______________________

9. Staff ID: ______________________ Staff initials v. ______________________

10. Client ID: ______________________ Comment v. ______________________

11. Mode: 1 - Administered by staff 2 - Administered by other 3 - Self-administered

13. Referral: MH ____ SA ____ ANG ____ Other ____ 14. Referral codes: ______________________

15. Referral comments: v1. ______________________

Scoring

Screener	Items	Past month (4)	Past 90 days (4, 3)	Past year (4, 3, 2)	Ever (4, 3, 2, 1)
IDScr	1a – 1f				
EDScr	2a – 2g				
SDScr	3a – 3e				
CVScr	4a – 4e				
TDScr	1a – 4e				
Supplemental questions	AQ5a-f				

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