ACTT Referral

WELCOME!

Mail or fax the completed application for to the address and fax number below:

Central Intake - Mental Health Clinic, 120 King Street West, North Bay, ON P1B 5Z7
Phone: 705-476-6240 ext. 6294 Fax: 705-476-6136

A/ Personal and Contact Information

Applicant:

First Name: _____ Last Name: _____

Address as of discharge: _____

Apt # _____ Telephone # _____ Ext:_____

City:_____ Province: _____ Postal Code: _____ Marital Status: _____

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 they are in regular contact that we can call in order to reach him/her (them?)?

Name:_____ Telephone #:_____ Relationship to applicant:_____

Can a message be left at the phone number provided: □ Yes □ No

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

_____

Does the applicant have a Trustee for finances: □ Yes □ No
If yes, please provide their name, address, and contact information:

_____

Date of Birth: (DD/MM/YYYY): _____ Gender (circle): Male Female Other Non-Binary Prefer Not to Say

Does the applicant have an Ontario Health Card: □ Yes □ No

HCN #: _____ Version code: _____ Exp. Date: _____

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 do they identify with)?

Culture/Ethnicity:_____ Citizenship/Immigration status:_____

B/ Referral Source Information (Please complete if not a self-referral)

Referent's name & title: _____ Agency: _____

B/ Referral Source Information (continued)

Telephone #:_____ Fax #: _____

Address: _____ City:_____ Province:_____ Postal Code: _____

Relationship to client:_____ Is the applicant aware of the referral: □ Yes □ No

Have you completed an Ontario Common Assessment of Need (OCAN) in the past 6 months with the applicant? □ Yes □ No

C/ Current Status

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

□ Self □ Parents □ Spouse/partner □ Spouse/partner & others □ Relatives □ Non-Relatives □ Children (ages) _____

Is the applicant currently homeless or at risk of becoming homeless: □ Yes □ No □ Somewhat: _____

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
□ Municipal Non-Profit Housing
□ Other:_____
□ Private House/Apt - Client owned
□ Rent
□ Private House/Apt. - Other/Subsidized
□ Retirement Home/Senior's Residence
□ Rooming/Boarding House
□ Supportive Housing - Congregate Living
□ Supportive Housing - Assisted Living
□ Long-Term Care Facility
□ Private Non-Profit Housing

What is the applicant's primary source of income?

□ ODSP
□ Pension
□ Family
□ Other:_____
□ Employment
□ Disability Insurance
□ No Source of Income
□ GIS (Guaranteed Income Supplement)
□ Employment Insurance
□ Social Assistance (e.g. Ontario Works)
□ CPP/OAS (Old Age Security)

What is applicant's current employment status?

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

What is the highest grade/level of education the applicant has attended? _____ What is their current education status?

□ Not in school
□ Trade School
□ Community College
□ Other:_____
□ Elementary/Junior High School
□ Vocational Training Centre
□ University
□ Secondary/High School
□ Adult Education
□ Unknown or Applicant Declined

D/ Health Information:

Is the applicant able 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:

_____

_____

D/ Health Information (continued):

What was the age of onset illness?_____

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

Has the applicant been to hospital (Emergency Department visits and/or in-patient stays) due to mental health challenges in the last 2 years?
□ Yes □ No □ Unknown

If so please estimate 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)

Hospital Name(s)	Dates To & From (DD/MM/YYYY to DD/MM/YYYY)
_____	_____
_____	_____
_____	_____
_____	_____

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 #_____

Does the applicant have a physician (e.g. GP, family doctor, walk-in clinic doctor)? □ Yes □ No
If yes, please provide the following information on the psychiatrist:

Name: _____ Telephone #_____

Does the applicant have any other illness/disabilities 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
Assistive Devices/ Mobility Aids	□ Yes	□ No	□ Unknown

If YES to any of these above, please describe:

_____

_____

Please complete the following list for all **current** psychotropic medications being used.

Drug Name	Dose	Start Date	Comments/Notes

Please indicate any **current** medical conditions and non psychiatric medications:

Medical Condition	Drug Name	Dose	Start Date	Comments/Notes

E/ Applicant's Support Needs:

Applicant requesting support with:

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

Referral source comments regarding the applicant's support needs:

_____

_____

_____

_____

We ask the following questions to determine if there are any safety or risk issues of which we should be aware. Answering any of these 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 suicidal threats or attempts:

_____

_____

_____

History of substance use or treatment:

_____

_____

_____

History of aggressive behaviour 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 their ability to receive services. It is to help us better direct the application)

□ Yes □ No □ Unknown

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), if there are current charges, please list the current charges and next court date, if on probabtiuon/parole, add probation end date:

_____

_____

F/ Existing Supports:

Is the applicant currently working with any other service providers?: □ Yes □ No □ Unknown
If yes, please provide the following information on each service provide 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 support) in the applicant's life and how satisfied they are with each of these supports:

_____

_____

_____

G/ Past Supports:

Has the applicant worked with other service providers in the past?: □ Yes □ No □ Unknown
If yes, please provide the following information on each service provider with whom the applicant previously worked:

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 support) in the applicant's life:

_____

_____

_____

H/ What are the applicant's goals for participation with ACTT Services?

_____

_____

_____

I/ Supporting Documentation: (Do not include what is available in NBRHC EMR)

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:

- □ **ALL** Hospital discharge summaries (complete history as available)
- □ Hospital Documentation (from last 3 months only)
  - Case reviews
  - Nursing notes
  - Treatment plan(s)
  - OT Assessments
- □ Specialty and/or specialist assessments (complete history as available)
- □ Previous relevant ACT Information
- □ Disposition Orders
- □ CTOs (Community Treatment Orders)

J/ Other Referrals

Has the applicant been referred to any other services?

_____

_____

_____

K/ Suitability

At times following the review, ACTT Services may not be found to be the best service match. Does the applicant / Substitute Decision Maker consent to forwarding this referral and assessment details to alternative community supports should it deemed more appropriate?

I _____ consent to have the personal information contained in this referral sent to an alternate community supports should it be found more appropriate.

Applicant or SDM Signature: _____ Date: _____

Applicant and Referent's Declaration & Consent

Consent forms allowing communication between the referral source and the North Bay Regional Health Centre, Nipissing Assertive Community Treatment Teams 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)