Central East LHIN Assertive Community Treatment Team (ACTT)
Common Referral Form

WELCOME!

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

Referral Screening Tool

The ACT model is based on a recovery-oriented, long-term community based intensive case management service with specific eligibility and admission criteria. It is important to note that referrals to ACT services should not be made with the expectation that the referral will facilitate an early discharge from an inpatient hospital admission. Other community supports should be considered in discharge planning until ACT services are able to admit clients considered appropriate for ACT services.

Exclusions – These clients would not be considered appropriate for ACT services:

1. Primary diagnosis of personality disorder, substance abuse, developmental disability, or organic disorders (all more appropriately treated by other specialized services).
2. Client is too violent or has other significant risks that would impact safe community care.
3. Client is in long term care/nursing home or Homes for Special Care.

Intake Criteria (* indicates required criterion)

1. **Aged 18 +*** ☐

2. Axis I diagnosis * ☐

- Examples: bipolar disorder, schizophrenia, or schizoaffective disorder

3. The applicant is willing to participate in the frequency and intensity of ACTT services ☐

4. Heavy system use: * ☐

- Hospital admissions (more than 50 days in past 2 years preferred)
- Increased use of medical/support services x 6 months (family doctor, emergency department, outpatient psychiatry, crisis services)
- Has not been successful in less intensive conventional mental health community services (including case management)

5. Intensive community support required: * ☐

Needs intensive support (i.e. ACT) in order to:

- Move from long term inpatient or supervised setting to the community, or,
- Avoid a long term institutional or residential placement if already in the community, or, Prevent long term institutional or residential placement because currently living with family and family supports are
- faltering or insufficient to meet the client's needs.

6. One or more of the following: *

i) Poor medication adherence and/or treatment resistant ☐

ii) Severe persistent functional impairment, such as:

☐

- Inability to consistently perform the range of practical daily living tasks required for basic adult functioning in the
- community (e.g. personal care, meal planning/cooking, homemaking tasks, budgeting, attending appointments)
- Difficulty with employment/vocational issues or carrying out the homemaker role (e.g. child care tasks)

iii) **Housing problems:**

☐

- Inability to maintain a safe living situation (e.g. homelessness, at risk of homelessness, multiple evictions, difficult to house)
- Needs supportive housing
- Able to live in more independent housing if intensive support is available

7. Additional factors:

i) Addictions: Co-existing substance abuse disorder x 6 months or longer ☐

ii) Legal involvement: In the past 2 years,

- Substantial jail time, recurring police involvement, Not Criminally Responsible/Ontario Review Board, or court diversion/involvement

Note: In the event that there are conflicting opinions between the ACT Team and the referring source with respect to a primary diagnosis and primacy of symptom presentation, the ACT Team shall exercise due diligence in gathering information from all available sources and the ACT Team's determination of the diagnosis at time of referral shall be viewed as definitive and shall determine acceptance or refusal of the referral.

Referral Form

Please answer as many questions as you can in each section. Please **PRINT** all answers in ink.
Should you have any questions or require assistance with filling in this form, please call **905-436-8760** and a staff person will be happy to help you.

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

Canadian Mental Health Association
60 Bond Street West
Oshawa, Ontario, L1G 1A5

Telephone Number: 905-436-8760 **Fax: 905-436-1569**

PART II

A/ Personal and Contact information?

Applicant:

First Name:________________________________Last Name:____________________________________

Street Address ____

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 you do not have a phone or are otherwise difficult to reach, is there someone with whom you are in regular contact that we can call in order to reach you?

Name:_________________________________Telephone No.:________________Extension:__________

Relationship to applicant:____

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

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

Do you have an Ontario Health Card: ☐ Yes ☐ No ☐ Don't know

Ontario Health Card Number: ________________________________

Do you speak English: ☐ Yes ☐ No ☐ Some

What is your first language(s): ☐ English ☐ French ☐ Other ____________________

What is your 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 your application:

What is your ethnicity and/or culture (i.e. what culture or ethnicity do you 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

Do you intend to remain involved with the applicant if he/she secures case management services? ☐ Yes ☐ No

If yes, please describe the level of involvement that you intend to maintain:

____

____

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

☐ Yes ☐ No ☐ Don't know / not sure

Who do you presently live with? Please check all boxes that apply:

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

Are you currently homeless or at risk of becoming homeless?

☐ Yes ☐ No ☐ Somewhat If Yes or Somewhat, Please explain: ____________________

What type of housing do you presently live in?

☐ Approved Homes & Homes for Special Care
☐ Correctional/Probationary Facility
☐ Domiciliary Hospital
☐ General Hospital
☐ Psychiatric Hospital
☐ Private House/Apt.- Client Owned /Market Rent
☐ Private House/Apt.- Other/Subsidized
☐ Retirement Home/Senior's Residence
☐ Rooming/Boarding House

☐ Other Specialty Hospital
☐ No fixed address
☐ Hostel/Shelter
☐ Long-Term Care Facility/Nursing Home
☐ Municipal Non-Profit Housing
☐ Supportive Housing – Congregate Living
☐ Supportive Housing – Assisted Living (RTF 24 Hr Home and Group Homes)
☐ Private Non-Profit Housing
☐ Other____

What is your primary source of income?

☐ ODSP
☐ Employment
☐ Pension
☐ Family
☐ CPP/OAS ________
☐ Social Assistance (e.g., Ontario Works)
☐ Employment Insurance
☐ Disability Assistance
☐ No Source of Income
☐ Other ________

What is your 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 Service Recipient Declined

What is the highest grade/level of education you have attained?___________ What is your current education status?

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

Are you currently or in the past been involved with the criminal justice system? (Please note, this will NOT affect your ability to receive service. It is to help us better direct your application)

☐ Yes ☐ No ☐ Don't know

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

____
____
____
____
____

D/ HEALTH INFORMATION

Is this your first experience with mental illness? ☐ Yes ☐ No ☐ Unknown

How long have you been experiencing mental health difficulties (i.e., length of time)?_______________

Have you been diagnosed with a mental illness? ☐ Yes ☐ No ☐ Unknown

If yes, what was the diagnosis(es)? Please be as specific and detailed as possible.

Have you 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 you 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 you have been in and the dates of your visit:

Hospital	Day/Month/Year to Day/Month/Year

Are you in hospital now due to mental health issues? ☐ Yes ☐ No

Are you currently on a Community Treatment order (CTO) order? ☐ Yes ☐ No

Do you have a psychiatrist?

Name: ____________________ Telephone #: ____________________

Do you have a physician (e.g., GP, family doctor, walk-in clinic doctor)?

Name: ____________________ Telephone #: ____________________

Do you have any other illnesses/disability?

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 list all current medications being used:

Please list all Mental Health medications used in the past, how long you used them, the highest dose you received and the reason why the medication was 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 you from service. We know these are sensitive questions and we appreciate you answering them. 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):

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

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History of any other risk or safety issue:

____

____

____

F/ EXISTING SUPPORTS

Are you 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 you are 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 your life and how satisfied you are with each of these supports.

____
____
____

G/ PAST SUPPORTS

Have you 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 you worked:

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

APPLICANT AND REFERRER'S DECLARATION & CONSENT

Consent forms allowing communication between the referral source and the Central East LHIN ACT Central Intake Service has been included? ☐ Yes ☐ No
Discharge summaries for all mental health hospitalizations have been included? ☐ Yes ☐ No
Legal history (charges, incarcerations, probation, court diversion, NCR status and ORB conditions) have 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:** ____________________