Community Treatment Order (CTO)

Confidential Referral Form

Canadian Mental Health Association Durham *Mental health for all*

Association canadienne pour la santé mentale Durham *La santé mentale pour tous*

Client Demographic Information				
First Name:			Last Name:	
Date of Birth (DD/MM/YY): / /	Age:	Gender: ☐ Female ☐ Male ☐ Other: _____	Marital Status:	Primary Language: ☐ English ☐ French ☐ Other: _____
Highest Level of Education:			Currently in school? ☐ Yes ☐ No	
Address:	City:		Province:	Postal Code:
Primary Phone Number:	With permission from the applicant, is there an alternative contact in the event we are unable to reach the applicant? Name: Phone Number: Relationship:			
Health Card Number:			Hospital Unique Number:	

CRITERIA FOR A COMMUNITY TREATMENT ORDER	
During the previous three years, the person:	
• Has been a patient in a psychiatric facility on two or more separate occasions	☐ Yes ☐ No
• Has been hospitalized at a psychiatric facility for 30+ consecutive days	☐ Yes ☐ No
• Has previously been on a Community Treatment Order	☐ Yes ☐ No
Client aware of referral: ☐ Yes ☐ No	Client agreeable to referral: ☐ Yes ☐ No
Has the client been deemed **incapable** to consent to treatment of a mental disorder? ☐ Yes ☐ No	
Is the client currently **contesting** the Form 33? ☐ Yes ☐ No	
If applicable, please attach a copy of the Form 33 and the associated Form 50 to this referral.	

Substitute Decision-Maker (SDM)			
SDM: ☐ Yes ☐ No	If yes, provide name:	SDM Agreeable to referral: ☐ Yes ☐ No	
Relationship:	Home Phone:	Cell Phone:	
Address:	City	Province:	Postal Code:

Medical Health History

Lakeridge Health Community Treatment Order (CTO) Program
1 Hospital Court, Oshawa, ON
Telephone: 905-436-8760 Ext. 305 | Fax: 905-436-8781

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Income & Medication Coverage
Source of Income: ☐CPP, ☐ Employment Insurance, ☐ ODSP, ☐ Ontario Works, ☐ Pension, ☐ Savings, ☐No Income ☐ Other: Medication Coverage: ☐ Yes – please specify: _____ ☐ No

Inpatient Psychiatric Hospitalization History	
Is the client currently admitted to hospital?: ☐ Yes ☐ No Diagnosis:	Current Status: ☐ Voluntary ☐ Involuntary (please specify): ☐ Form 1 ☐ Form 3 ☐ Form 4
Does the applicant a history of harm to self and/or others?: ☐ No ☐ Yes – please specify:	
Date of admission (DD/MM/YYYY): / /	Estimated Discharge Date (DD/MM/YYYY): / /
To meet eligibility criteria, please list date(s) of previous psychiatric hospitalizations and length of stay within the last three years:	

Legal History				
☐ Court Diversion Program	☐ Not Criminally Responsible (NCR)	☐ Probation	☐ Restraining Order	☐ Other (please specify):

Psychiatry and Community Supports		
Issuing Psychiatrist:	Telephone:	Fax:
Monitoring Psychiatrist: Aware of Referral? ☐ Yes ☐ No	Telephone:	Fax:
Family Physician (If applicable):	Telephone:	Fax:

Please list any individuals or agencies that are currently providing community services to the applicant (please include, if applicable, who will be administering any long-acting Injections):

Agency/ Service Provider	Contact Person	Role	Telephone & Fax Numbers

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Medications (please attach medication list, if available)	
Medication	Dose & Frequency

The purpose of this referral form is to determine whether or not someone is eligible for CTO services.

Please acknowledge the following statements prior to sending a referral to CTO:

- All relevant documentation is included with this referral (e.g., consultation notes, psychiatric assessments, hospital discharge summaries, Form 33, neuropsychological testing, medication list).

- The referral source will remain involved in care or make alternative care arrangements until the applicant is assessed and program eligibility is determined.

Please fax the completed referral form to (905) 436-8781. Once the referral is received, our CTO Coordinator will perform an assessment to determine the applicant's eligibility and suitability for our program. If the applicant is not eligible for services, the referral source will be notified.

Please note, incomplete referrals will be sent back to the referral source and will not be processed until all the information is completed in full. Thank you for your referral.

Referral Information	
Referral Completed by:	
Telephone (including extension):	Fax:
Referral Source Signature: _____	Date of Referral (DD/MM/YYYY): _____