Canadian Mental Health Association Durham
Mental health for all

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

Lakeridge Health

Community Treatment Order (CTO)

Confidential Referral Form

<u>The purpose of this referral form is to determine whether someone is eligible for CTO services.</u>

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.

Any incomplete referrals <u>will be sent back</u> to the referral source and will not be processed until all the information is completed in full.

Thank you for your referral.

CLIENT DEMOGRAPHIC INFORMATION

First name:		Last name:	
Date of birth: _____ /_____ / _____ DD MM YYYY Current age: _____	Gender: ☐ Female ☐ Male ☐ Transgender ☐ Transexual ☐ Other: _____	Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Primary language: ☐ English ☐ French ☐ Other: _____
Highest level of education: ☐ Elementary ☐ High School ☐ Post-secondary ☐ Graduate Other:		Currently in school? ☐ Yes ☐ No	

What is your Ethnicity and/or Culture (i.e.; What culture or ethnicity do you identify with)?

Culture/Ethnicity: _____Citizenship/Immigration status: _____

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

☐ Self ☐ Spouse / Partner ☐ Other_____ ☐ Parents ☐ Relatives

☐ Non-relatives ☐ Children (age and sex of children): _____

Address:	City:	Province:	Postal Code:

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Is the client homeless or at risk of becoming homeless?	☐ Yes ☐ No ☐ Transient housing. Please explain: _____
What type of housing does the client presently live in? ☐ Approved homes/homes for special care ☐ Psychiatric hospital ☐ Correctional/probation facility ☐ Private house/apartment – client owned ☐ Retirement home ☐ General hospital ☐ Rent ☐ Rooming / boarding house ☐ Other: _____	
Primary phone number:	With permission from the applicant, is there an alternative contact in the event we are unable to reach the applicant?
Primary email address:	Name: Phone Number:
Can a message be left at the phone number provided? ☐ Yes ☐ No	Relationship:

Health card number: __ __ __ __ - __ __ __ - __ __ __ - __ __ EXP:	Hospital MRN:

CRITERIA FOR A COMMUNITY TREATMENT ORDER

During the previous 3 years, the person;

▪ Has been hospitalized at 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:	Primary phone number:	Email address:	
Address:	City:	Province:	Postal code:

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INCOME & EMPLOYMENT

Source of Income:

☐ CPP ☐ Employment Insurance (EI) ☐ ODSP ☐ Ontario Works (OW) ☐ Pension ☐ Savings ☐ OSAP ☐ No Income

☐ Other:

What is the client's current employment status?

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

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 (3) three years:

Hospital	Length of stay

Is this the client's first experience with mental illness? ☐ No ☐ Yes ☐ Unknown

How long has the client been experiencing mental health difficulties? (i.e., length of time?):

LEGAL HISTORY

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

If legal history has been indicated, please provide further details:

_____

_____

_____

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RELEVANT HEALTH HISTORY
Does the client have any illnesses and/or disabilities? ☐ Yes ☐ No Concurrent Disorder (substance use and mental Illness)? ☐ Yes ☐ No Dual Diagnosis (developmental disability and mental illness)? ☐ Yes ☐ No Neurological (e.g., head/brain injury, epilepsy, Parkinson's, cognitive disorders etc.)? ☐ Yes ☐ No Other chronic illness/ physical disabilities (e.g., hypertension, diabetes, allergies)? ☐ Yes ☐ No If yes has been answered for a neurological and/or chronic illness and/or disability, please provide further details:
History of substance use or treatment? ☐ Yes ☐ No If yes, please provide further details: _____ _____
History of destruction to property? ☐ Yes ☐ No If yes, please provide further details: _____ _____ _____
History of violence? ☐ Yes ☐ No If yes, please provide further details: _____ _____ _____
History of self-harm or suicide? ☐ Yes ☐ No If yes, please provide further details: _____ _____ _____
History of any other risk factors? ☐ Yes ☐ No If yes, please provide further details: _____ _____ _____

PSYCHIATRY AND COMMUNITY SUPPORTS		
Issuing Psychiatrist:	Telephone:	Fax:
Monitoring Psychiatrist:	Telephone:	Fax:

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Aware of referral? ☐ Yes ☐ No		
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

SUPPORT NEEDS

☐ Managing specific symptoms of a serious mental illness ☐ Finances ☐ Housing needs
☐ Substance abuse / addictions
☐ Legal issues ☐ Developing daily living skills ☐ Educational opportunities ☐ Employment/occupational/vocational
☐ Relationships ☐ Social needs
☐ Other: _____

Additional comments regarding applicant's support needs:

PAST SUPPORTS

Has the client 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:

Agency	Name/Contact Person	Services Received	Telephone Number

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MEDICATION / PHARMACY INFORMATION (Please attach medication list, if available)	
Medication	**Dose & Frequency**

Medication coverage: ☐ Yes – please specify: _____ ☐ No

What pharmacy is the client currently using?

Name:

Address:

Phone:

Fax:

Would the client be willing to use CMHA's partner pharmacy?

PharmaChoice at 60 Bond St. W, Oshawa, ON

Phone: 905-579-5111 | Fax: 905-579-7464

☐ Yes ☐ No ☐ Unsure

REFERRAL INFORMATION

Referral completed by:

Telephone (including extension):	Fax:
Referral source signature: _____	Date of referral (DD/MM/YYYY): _____