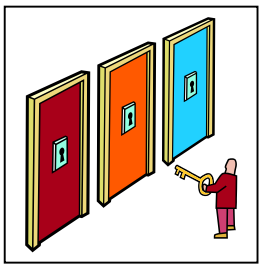

District of Nipissing

Community Mental Health & Addictions Long-Term Support Services

COMMON REFERRAL FORM

Version: 2018.07

Assertive Community Treatment Team (ACTT) Service
North Bay Regional Health Centre
phone 705-494-3031 fax 705-494-6104

Case Management
Addiction Supportive Housing,
North Bay Recovery Home
phone 705-472-2873 fax 705-472-6442

Intensive Case Management Program
Alliance Centre,
West Nipissing General Hospital
phone 705-753-2271 fax 705-753-4202

Intensive Case Management Program
- **North Bay & Area**
- **East Nipissing**

Nipissing Mental Health Housing & Support Services
phone 705-476-4088 fax 705-495-3585

Peer Support Services
People for Equal Partnership in Mental Health (PEP)
phone 705-494-4774 fax 705-494-4775

Community Support Service
Canadian Mental Health Association,
Nipissing Regional Branch
phone 705-474-1299 fax 705-474-5325

The District of Nipissing programs listed above work together to find the best service for people in need of long-term community mental health and/or addictions support. They form the Common Referral Triage Team, and receive and review all referrals to make this determination.

The person seeking service may complete this form or someone else may do so on their behalf. Only one Common Referral Form needs to be completed for consideration for any of the above-listed services.

Please complete the Form as fully and accurately as possible, printing or writing legibly. You may also complete it electronically and then print for signatures. The Triage Team needs this information to make sure that the best referral is made in the shortest time possible. Information provided on this form helps inform their decision; it is not intended as an assessment or an intake.

Upon completion, you, as the person seeking services or your substitute decision maker signs the final page. After reviewing the referral, the Triage Team will communicate their decision to you. If they determine that none of the listed services are suitable to your stated needs, they will forward your referral to a service that may better fit your needs if you have initialed the box on the final page that indicates your consent to do so.

Please complete all six pages of this form and send to any of the above-listed agencies. All are able to provide more information, if needed.

A. Identifying Information for Person Being Referred

Name: _____ Date of Birth: _____|_____|_____ Age _____
Day / Month / Year

Gender_____ Aboriginal _____Non Aboriginal _____ Health Card # _____

Preferred Language: English ☐ French ☐ Other: _____

Language 1st Spoken: English ☐ French ☐ Other: _____

Language still understood: English ☐ French ☐ Other: _____

Address of residence: _____

_____ Postal Code: _____

Mailing Address (if different from above): _____

Postal Code: _____ Email: _____

Phone # (preferred) _____ Can a message be left at this #? ☐ Yes ☐ No

Phone # (alternate) _____ ☐ Yes ☐ No

Alternate Contact name, phone # & relationship: _____ ☐ Yes ☐ No

Currently incarcerated in Correctional Facility? ☐ Y ☐ N

Current Family Physician: _____ Aware of this referral? ☐ Y ☐ N

Current Psychiatrist: _____ Aware of this referral? ☐ Y ☐ N

B. Referral Source Information

Is this a self-referral? ☐ Y ☐ N If "yes" skip to **Section C**. If not, complete below.

Name of Person Making Referral: _____

Position or relationship: _____ Phone Number: _____

Address: _____

Postal Code: _____ Email: _____

Can we contact this Referral Source? ☐ Y ☐ N

Name: _____ Date of Birth: _____|_____|_____
Day / Month / Year

C. Psychiatric Information

Psychiatric Diagnosis: Primary: _____

Secondary: _____

Who provided this diagnosis & approximately when? _____

Dates and length of each **hospitalization for psychiatric reasons**, to either general or psychiatric hospital (most recent to oldest): (Please attach sheet if more spaces needed.)

Date(s) (mm/yy)	Length of Stay	Name and Location of Hospital

Currently in hospital?: ☐ Yes ☐ No. If yes, estimated date of discharge : _____

Number of visits to an emergency room, **for psychiatric reasons**, in the past six months:	

Criteria for Serious Mental Illness:

- Has the psychiatric illness(es) been present for more than ten years? ☐ Yes ☐ No
- Anticipated duration of psychiatric illness is more than ten years? ☐ Yes ☐ No
- Psychiatric illness has resulted in difficulties that interfere with capacity to function in one or more major life activities? ☐ Yes ☐ No

Has an **OCAN** (Mental Health Assessment) been completed within the last (6) six months? ☐ Y ☐ N
If "yes", where? _____

Name: _____ Date of Birth: _____|_____|_____

D. Services Currently in Place (Please list specific services, if applicable, beside agency)

- ☐ ACTT _____
- ☐ Addiction and After-Care Services _____
- ☐ CMHA _____
- ☐ Alliance Centre _____
- ☐ East Nipissing Mental Health Services _____
- ☐ Nipissing Mental Health Housing & Support Services _____
- ☐ People for Equal Partnership in Mental Health (PEP) _____
- ☐ North Bay Regional Health Centre Mental Health Clinic _____
- ☐ NE LHIN Home – Community Care _____
- ☐ Probation and Parole _____
- ☐ Other: _____

E. Addiction Information

Is the person seeking service living with an addiction?

☐ Yes. Please complete this section
☐ No. Skip to **Section E**.

Please specify: _____

_____

When was the last ADAT completed?
(Addiction Assessment Tool) Day_____ Month _____ Year _____

Where was the last ADAT completed? Organization or institution:_____

Phone: _____ Address: _____

Dates, lengths, and locations of treatment for addiction: (Please attach sheet if more spaces needed.)

Date(s) (mm/yy)	Length of Stay	Name and Location of Treatment Facility

Number of visits to an emergency room or detoxification facility **for addiction reasons**, in the past six months:	

Name: _____ Date of Birth: _____|_____|_____

F. Medical Information

Medication -List all current / best possible medication history including psychiatric and non-psychiatric medication, over-the-counter products (e.g. Tylenol, Gravol) and/or alternative medications (e.g. St. John's Wort) being used. Include dose and frequency if known.
List Attached: ☐ Yes ☐ No (If "no", list below)

Are medications taken as prescribed? : ☐ Yes ☐ No (If "no", please explain)

_____

_____

Has the person seeking service experienced an **Acquired Brain Injury**?
☐ Yes (Provide details) ☐ No ☐ Unknown

_____

_____

Are there **other medical conditions** that may have an impact on the person's fit with mental health or addictions services? ☐ Yes (Describe below) ☐ No ☐ Unknown

_____

_____

_____

G Risk Information

Please indicate relevant past and current risk factors:

☐ violence towards others

☐ concealing weapons

☐ falling (if yes, describe functional mobility/assistive devices)

☐ violence towards self

☐ violence towards property

☐ legal involvement

☐ risks in the home environment

☐ sexual aggression

☐ fire-setting

☐ suicide

☐ other :

_____

_____

_____

Provide relevant details:
Allergies (Food/Drug/Environmental):

Name: _____ Date of Birth: _____|_____|_____

H. Reasons for Referral/Assistance Needed

Mark an X showing approximately how often assistance is needed for each area.	**Daily**	**Weekly** ~1-2 times / week	**Monthly** ~1-2 times /month	**None**	**Unknown**
Assistance with Medication (please specify):					
Reducing impact of psychiatric symptoms					
Maintaining needed medical, psychiatric or support services(formal or self-help). (e.g.remembering appointments, following through on plan of care, etc.)					
Assistance with physical health issues					
Dealing with problem substance use					
Maintaining appropriate housing					
Remaining engaged with educational programs or remaining employed.					
Support/advocacy with pending/current criminal charges					
Living skills (e.g.cooking, personal care, etc.)					
Other (specify)					
Other (specify)					

I. Referral Source Suggestion(s)

Based on your assessment of the person seeking service, which long-term community mental health & addictions services would you suggest might be the best fit.

Note: The Triage Team will consider your suggestions in making their final determination of where to direct the person's referral.

☐ Unsure

☐ Assertive Community Treatment Team (ACTT) - District of Nipissing
☐ Intensive Case Management - West Nipissing
☐ Intensive Case Management - East Nipissing
☐ Intensive Case Management - North Bay & area
☐ Case Management - Addiction Supportive Housing (ASH)
☐ Community Support Service
☐ Peer Support Services

Name: _____ Date of Birth: _____|_____|_____

J. Other

Is there information that could help in the decision of which service would best meet your needs?
It is helpful if you summarize current issues and primary reason for referral.
You may also use this space to elaborate on other responses.

Name: _____ Date of Birth: _____|_____|_____

K. RELEASE OF INFORMATION

Important information for the person seeking service.

The purpose of this Form is to provide information to the Common Referral Triage Team so they can identify the service which is best suited to your needs. The Triage Team may need to contact programs identified on this Form that you are already receiving service from. Once the service that is most appropriate for your situation is identified, the Triage Team will need to release a copy of this Form to that service.
By signing below, you are agreeing to this release of information.

As well

- This Form will only be used in this way for ninety (90) calendar days after the date that you sign below. After that, if you still are seeking service, you will need to complete a new release.
- The Triage Team will advise you which service will contact you about your referral. If someone else completed this referral on your behalf, they will also be notified which agency your referral has been directed to.

Person seeking service (or substitute decision-maker)
Name (printed): _____ Date: _____

Signature: _____

If you have made your mark above rather than signing, or if a Substitute Decision-maker has completed this Form, please have the mark/signature witnessed:

Witness
Name (printed): _____ Date: _____

Signature: _____

NOTE: If after reviewing your referral, the Triage Team determines that none of the listed services are suitable to your stated needs, **they will forward your referral to a service that may better fit your needs if you initial this box.**

Your initials ☐

Submit this completed & signed form to any of the agencies listed on the first page. Thank you.