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. Please also 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):

____

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

____

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:** _____________________