



## Huron Perth Healthcare Alliance Assertive Community Treatment Team Referral Form

The Assertive Community Treatment Team (ACTT) model is based on a recovery-oriented, long-term community based intensive multi-disciplinary support. It is important to note that referrals to ACTT services should not be made with the expectation that the referral will facilitate early discharge from inpatient hospital admission. Other community supports should be considered in discharge planning until ACTT services are able to admit clients considered appropriate for ACTT services.

Please consult with ACTT for clarification or for more information to complete the ACTT referral form.

### **Information for Referral Source**

- Endorsement from a Primary Care Provider (Physician or Nurse Practitioner) may be required in any of the Outpatient Mental Health Services Programs
- Information marked “required” on the referral form must be completed in full
- Information requested on the referral form may be sent as a separate attachment if there is insufficient space on the referral form
- The referral source must inform whether subsequent referrals were made to similar programs to avoid duplication
- Communication regarding service connection will be provided to the referral source via fax and/or telephone

**Note:** if a referral needs to be cancelled for any reason, please contact Central Intake at 519-272-8210 extension 2570 or fax 519-272-8226.

**Note:** ACTT shall exercise due diligence in gathering information and ACTT’s determination of the diagnosis at time of referral shall be viewed as definitive and shall determine acceptance or decline of the referral.

### **Information for Individuals Being Referred**

- Individual being referred and/or Substitute Decision Maker(SDM)/Caregiver/individual holding Power of Attorney must be aware that a referral is being made to the Huron Perth ACTT
- Appointment booking will be communicated via telephone to the client and/or SDM/Caregiver/individual holding Power of Attorney and/or via fax to the referral source
- If an individual’s contact information changes, they and/or SDM/Caregiver/individual holding Power of Attorney are responsible to notify the program or their Mental Health Clinician.
- ACTT staff will make all reasonable attempts to contact the individual/SDM /Caregiver/individual holding Power of Attorney. If contact cannot be made, the file will be closed and the referral source will be notified
- Individuals can contact Outpatient Mental Health Services to receive an update on the status of their referral by calling Central Intake at 519-272-8210 extension 2570.

### **How to Submit the Huron Perth Assertive Community Treatment Team Referral Form**

- Please fax the completed Referral Form to **519-272-8226** (each referral must be faxed separately)
- To help us provide the best care possible, please complete all pages of the referral form and include all relevant documents, such as previous psychiatric consultations, discharge summaries, medication administration records, psychological/mental health notes, lab and test results, and medical information.

If an individual is in crisis, direct them to the **Huron Perth Helpline and Crisis Response Team** at **1-888-829-7484** or their nearest Emergency Department. If an individual is experiencing an emergency, **9-1-1** should be contacted.

If you have any further questions or concerns, please contact Central Intake at 519-272-8210 extension 2570.



## Huron Perth Healthcare Alliance Assertive Community Treatment Team Referral Form

### Reason for Referral and Criteria Checklist – Required *(check all that apply)*

- 18 years of age or older
- Axis I diagnosis (example: bipolar disorder, schizophrenia, co morbid substance abuse, or schizoaffective disorder)
- Willing to participate in the frequency and intensity of ACTT services
- Heavy system use:
  - Hospital admissions (more than 50 days in the past 2 years preferred)
  - Increased use of medical/support services over 6 months (Primary Care Provider, Emergency Department, outpatient psychiatry, crisis services, etc.)
  - Has not been successful in less intensive conventional mental health community services (including case management)
- Intensive community support required 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 not meeting the client's needs.
- One or more of the following:
  - Poor medication adherence and/or treatment resistant
  - Severe persistent functional impairment, such as inability to consistently perform the rfrgrange 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)
- Housing concerns:
  - 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
- Additional factors:
  - Addictions: Co-existing substance abuse disorder over 6 months or longer
  - Legal involvement in the past 2 years
  - Substantial jail time, recurring police involvement, not criminally responsible/Ontario Review Board, or court diversion/involvement
- Resident of Huron or Perth County

**Date of Referral:** \_\_\_\_\_ *(DD/MM/YYYY)* **Date Referral Received *(office use only)*:** \_\_\_\_\_

### Client Demographic Information – Required *(please print)*

Client's Legal Name *(first name, last name)*: \_\_\_\_\_

Preferred Name *(if different from above)*: \_\_\_\_\_

Date of Birth *(DD/MM/YYYY)*: \_\_\_\_\_ Sex Assignment at Birth:  Male  Female  Intersex

Gender Identity: \_\_\_\_\_ Pronouns: \_\_\_\_\_

Ethnicity and/or culture (i.e. what culture or ethnicity do they identify with): \_\_\_\_\_

Address: \_\_\_\_\_  No Fixed Address  
(Street, Town, Province, Postal Code)

Telephone: \_\_\_\_\_ *(home/cell/work/other)*

Consent to contact by telephone:  Yes  No      Consent to leave detailed voicemail:  Yes  No

Consent to speak with others in the household/alternative contact person:  Yes  No

If yes, please specify *(name/relationship)*: \_\_\_\_\_

Household language:  English  French  Other: \_\_\_\_\_



## Huron Perth Healthcare Alliance Assertive Community Treatment Team Referral Form

**Client Health Card Information - Required**

Health Card Number: \_\_\_\_\_ Version Code: \_\_\_\_\_

**Additional Considerations**

Mobility    Audio    Visual    Language    Interpreter Services Required    Service Animal  
 Other: \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

**Primary Care Provider** *(if applicable)*

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Family Health Team (FHT) / Medical Clinic: \_\_\_\_\_

**Service Provider Information** *(if applicable)*

Name/Agency/Program: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Substitute Decision Maker / Caregiver / Power of Attorney – Required**

*By providing this information, the Referral Source confirms that the individual being referred consents for the HPHA to call the Substitute Decision Maker/Caregiver/individual holding Power of Attorney on their behalf. The HPHA will refrain from communicating Personal Health Information until consents are verified.*

Does the client have a Substitute Decision Maker/Caregiver/ Power of Attorney:  Yes  NoIf yes, for  Treatment **or**  Finance

Name of Substitute Decision Maker/Caregiver/Power of Attorney: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Telephone: \_\_\_\_\_ *(home/cell/work/other)*Consent to leave detailed voicemail:  Yes  No

Comments: \_\_\_\_\_

**Referral Source Information - Required**

*HPHA requires the referring Primary Care Provider or the individuals Most Responsible Person to continue to be available for ongoing medical care*

Primary Care Provider (PCP)    Emergency Department Physician    Hospitalist    Psychiatrist  
 Professional Referral    Self or Caregiver Referral    Other: \_\_\_\_\_

Name/Agency/Program: \_\_\_\_\_

FHT / Medical Clinic *(if applicable)*: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Billing Number *(if applicable)*: \_\_\_\_\_ CPSO Number *(if applicable)*: \_\_\_\_\_**I will continue to provide medical care and ongoing follow-up to this client (required):**  Yes  No**Current Status - Required****Living Arrangements** *(self, spouse, parent(s), long-term care, group home, roommate(s) etc.):*

\_\_\_\_\_

\_\_\_\_\_

**Income Information:**  CPP    Employment Insurance    ODSP    Ontario Works    Pension Savings    No Income    Other: \_\_\_\_\_



## Huron Perth Healthcare Alliance Assertive Community Treatment Team Referral Form

**Legal History:**  Court Diversion Program  Not Criminally Responsible  Probation

Restraining Order  Other: \_\_\_\_\_

**Education:** Are you in school:  Yes  No If yes, please specify \_\_\_\_\_

**Presenting Concerns – Required** *(attach if details cannot fit in the space provided)*

*Please provide a brief narrative explaining presenting concerns and symptoms, including duration and frequency of symptoms, psychosocial factors, substance use issues and all other current and historical information that is relevant:*

**Desired Outcome – Required** *(attach if details cannot fit in the space provided)*

*Please check all that apply and provide a brief narrative explaining the desired outcome and any information that is relevant:*

Severe Mental Health Symptom Support

Finance Support

Housing Support

Legal Support

Educational Opportunities

Occupational / Employment / Vocation

Peer Supports

Relationships

Developing Activities of Daily Living Skills

Other: \_\_\_\_\_

**Mental Health Services Involvement – Required** *(attach if details cannot fit in the space provided)*

Organization Name: \_\_\_\_\_

Current Involvement:  Yes  No

Describe Involvement: \_\_\_\_\_

Organization Name: \_\_\_\_\_

Current Involvement:  Yes  No

Describe Involvement: \_\_\_\_\_

**Psychosocial, Accommodation or Risk Factors** *(if applicable)*

**Home Visit Concerns**

Are there any known safety risks staff should be aware of in delivering service? *(such as history of violence/aggression, history of sexual assault, access to weapons, domestic violence, smoking in the residence, animals in the residence):* \_\_\_\_\_



# Huron Perth Healthcare Alliance Assertive Community Treatment Team Referral Form

## **Risk Factors** *(please check all that apply)*

### **Past:**

- Suicidal ideation
- Suicidal ideation with a plan
- Suicide attempt(s)
- Self-injurious behaviour(s)
- Thought to harm others
- Plan to harm others
- Aggressive/violent behaviour
- Delusions or hallucinations
- Addiction concerns/overdosing history
- Housing Stability

### **Present:**

- Suicidal ideation
- Suicidal ideation with a plan
- Suicide attempt
- Self-injurious behaviour(s)
- Thought to harm others
- Plan to harm others
- Aggressive/violent behaviour
- New/increasing delusions or hallucinations
- Addictive behaviours
- Housing Stability

Comments: \_\_\_\_\_

Is there a history of violence:  Yes  No

Does the client have a history of harm to self and/or others:  Yes  No

If yes, please specify: \_\_\_\_\_

## **Psychiatric / Medical History – Required** *(attach if details cannot fit in the space provided)*

Date of Most Recent Psychiatric Assessment *(if applicable)*: \_\_\_\_\_

Location/Physician: \_\_\_\_\_

Client's Current Mental Health Diagnoses: \_\_\_\_\_

Is the client currently admitted to hospital:  Yes  No If yes, please specify:

- Date of Admission *(DD/MM/YYYY)*: \_\_\_\_\_
- Estimated Date of Discharge *(DD/MM/YYYY)*: \_\_\_\_\_
- Current Status:  Voluntary  Involuntary *(please specify)*:  Form 1  Form 3  Form 4

Is the client currently on a Community Treatment Order:  Yes  No

Please list date(s) of previous psychiatric hospitalizations and length of stay within the last three years:

\_\_\_\_\_  
\_\_\_\_\_

Does the client has other illnesses/disabilities (concurrent disorders, dual diagnosis, neurological, other chronic illness/physical disabilities [hypertension, diabetes, allergies]):  Yes  No

If yes, please specify: \_\_\_\_\_

## **Medications - Required** attached

*Please include both psychiatric and non-psychiatric medication (dose, frequency, adverse effects), including all current and previously trialed medications. Please attached a medication list if the medications are expansive of the space provided.*



# Huron Perth Healthcare Alliance Assertive Community Treatment Team Referral Form

**Other Information Pertinent to the Referral**  attached (if applicable)

Please attached relevant notes, assessments, consults.

## Supplemental Information

*This information is highly valued. Please check all that are attached with this referral.*

- Hospital Discharge Summaries
- Hospital Documentation (within the last 3 months):  Case Review  Nursing Notes  Treatment Plan(s)
- Psychiatric Hospitalization(s)
- Specialty and/or Specialist Assessments
- Disposition Orders
- Community Treatment Order(s)
- Form 21 – Certificate of Incapacity to Manager One’s Property
- Form 22 – Financial Statement
- Form 24 – Notice of Continuance of Certificate of Incapacity to Manage One’s Property
- Form 33 – Notice to Patient
- Other Assessments (e.g. GDS, PHQ-9, GAD-7): \_\_\_\_\_

Is the client and/or Substitute Decision Maker/Caregiver/Power of Attorney aware of this referral:  Yes  No

Does the client and/or Substitute Decision Maker/Caregiver/Power of Attorney consent to this referral:  Yes  No

**Please note, the client and/or Substitute Decision Maker/Caregiver/individual holding Power of Attorney must consent to a referral being made on their behalf to HPHA Outpatient Mental Health Services.**

\_\_\_\_\_  
**Name** (PCP, Professional, Self or Caregiver)

\_\_\_\_\_  
**Signature** (PCP, Professional, Self or Caregiver)

\_\_\_\_\_  
**Date** (DD/MM/YYYY)

Thank you for making a referral to the Huron Perth Assertive Community Treatment Team. Your involvement in this client’s care is important to us; if you have any questions or concerns, or wish to provide updated client information, please contact Central Intake at **519-272-8210 extension 2570** or **by fax 519-272-8226**.