Huron Perth Healthcare Alliance
Transition Bed Program 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

Note: if a referral need to be cancelled for any reason, please contact the Transition Bed Program at 519-482-3440 extension 6296 or by fax 519-482-8510 to inform us of the change.

Information for Individuals Being Referred

- The individual being referred must be aware that a referral is being made to the Huron Perth Healthcare Alliance (HPHA) Transition Bed Program
- Appointment booking will be communicated via telephone to the client/caregiver and/or via fax to the referral source
- If an individual's contact information changes, they and/or their Substitute Decision Maker are responsible to notify the program or their Mental Health Clinician.
- HPHA staff will make three attempts to contact the individual by telephone. 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 the Transition Bed Program at 519-482-3440 extension 6296.

How to Submit the HPHA Transition Bed Program Referral Form

- Fax the completed Referral Form to **519-482-8510** (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, 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 the Transition Bed Program at 519-482-3440 extension 6296.

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Referral and Criteria Checklist – Required

☐ 18 years of age or older
☐ In a self-identified crisis such as homelessness, mental health or addiction issues, involvement in the criminal justice system and/or suicidal ideation with no plan
☐ Agrees to work on recovery focused goals
☐ Agrees to take own medication as prescribed and is able to obtain and administer their own medication, if applicable
☐ Able to attend to Activities of Daily Living (example: mobility [ability to climb stairs], personal hygiene)
☐ Consents to an in-person assessment after the referral form has been completed

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

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

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

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

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: _______________

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: ☐ Yes ☐ No

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

Household language: ☐ English ☐ French ☐ Other: _______________

Physical Description *(height, weight, eye colour, hair colour and length, complexion, any distinguishing features)*:
____

Living Arrangements *(self, spouse, parent(s), long-term care, group home, etc.)*: _______________
____

Income Information: ☐ Ontario Works ☐ Ontario Disability Support Program ☐ Employment Insurance
☐ Other: _______________

Currently involved in the Court System: ☐ Yes ☐ No If yes, please specify: ☐ Criminal ☐ Family

Been criminally charged: ☐ Yes ☐ No If yes, please specify: _______________

Client Health Card Information - Required

Health Card Number: _______________ Version Code: _______________

Primary Care Provider *(if applicable)*

Name: _______________ Telephone: _______________

Family Health Team (FHT) / Medical Clinic: _______________

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Additional Considerations

☐ Mobility ☐ Audio ☐ Visual ☐ Language ☐ Interpreter Services Required ☐ Service Animal

☐ Other: ______________________ If yes, please explain: ____________________________________

Presenting Concerns – Required *(please 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:

☐ Housing
☐ Chronic Suicidal Ideation with no plan
☐ Abuse *(sexual, physical, emotional, financial)*
☐ Self-Harm
☐ Other: ____

☐ Financial/Employment Assistance
☐ History of Aggression or Violence
☐ Legal Involvement
☐ Grief/Traumatic Loss

☐ Substance Use
☐ Mental Health Symptoms
☐ Activity of Daily Living Assistance
☐ Problems with Relationships

If indicated above, please provide:

The last date of substance use: ____

More information about the history of aggression or violence *(i.e. current thoughts, last act of aggression, etc.)*:

____

More information about the history of self-harm *(i.e. current thoughts, last attempt, risky behaviour etc.)*:

____

More information about the history of suicidal ideation/attempts or putting themselves at risk *(i.e. current thoughts, last attempt, risky behaviour etc.)*: ____

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

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

Location/Physician: ____

Past Psychiatric Hospitalizations: ____

____

Out of Home Placements: ____

____

Client's Current Mental Health Diagnoses: ____

____

Service Provider Information

Case Worker: ______________________________________ Telephone: ________________________

Organization Name: ____

Describe Involvement: ____

____

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Case Worker: ____ Telephone: __________________________

Organization Name: ____

Describe Involvement: ____

____

Mental/Physical Health - Required

Please provide a list and details of any relevant medical/physical considerations (e.g. specific illnesses, chronic pain, difficulty coping with medical illness, etc.)

Allergies: ☐ Yes ☐ No

If yes, please specify: ____

Medications - Required ☐ **attached**

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

____

Name

____ ____

Signature **Date** *(DD/MM/YYYY)*

Thank you for making a referral to the HPHA Transition Bed Program. 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 the Transition Bed Program at **519-482-3440 extension 6296** or **by fax 519-482-8510**