Huron Perth Healthcare Alliance
Community Treatment Order Program
Referral Form

Information for Referral Source

- A referral from a Primary Care Provider (Physician or Nurse Practitioner) or Psychiatrist is ***required*** for the Community Treatment Order Program
- 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

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 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) Community Treatment Order 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.
- 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 HPHA Specialized Outpatient Mental Health Services Referral Form

- 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.

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Referral and Criteria Checklist - Required

During the previous three year period you:

☐ Have been a patient in a psychiatric facility on two or more separate occasions or for a cumulative period of 30 days or more during that three year period **OR**

☐ Have been the subject of a previous Community Treatment Order (CTO)

I am in the opinion that:

☐ The person is suffering from mental disorder such that they need continuing treatment or care and continuing supervision while living in the community **AND**

☐ If the person does not receive continuing treatment or care and continuing supervision while living in the community, they are likely, because of mental disorder to (choose one or more of the following):

- ☐ cause serious bodily harm to them self, **OR**
- ☐ cause serious bodily harm to another person, **OR**
- ☐ suffer substantial mental deterioration of the person, **OR**
- ☐ suffer substantial physical deterioration of the person, **OR**
- ☐ suffer serious physical impairment of the person

AND

☐ The person is able to comply with the community treatment plan contained in the community treatment order, **AND**

☐ The treatment or care and supervision required under the terms of the community treatment order are available in the community, **AND**

☐ If the person is not currently a patient in a psychiatric facility, the person meets the criteria for the completion of an application for psychiatric assessment under subsection 15(1) or (1:1) of the *Mental Health Act*

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: _____

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: _____

Legal History: ☐ Court Diversion Program ☐ Not Criminally Responsible ☐ Probation ☐ Restraining Order ☐ Other: _____

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: _____

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Referral Source Information - Required

☐ Primary Care Provider (PCP) ☐ Psychiatrist

Name: _____

Family Health Team / Medical Clinic *(if applicable)*: _____

Address: _____

Telephone: _____ Fax: _____

Billing Number *(if applicable)*: _____ CPSO Number *(if applicable)*: _____

Substitute Decision Maker - Required

Name of Substitute Decision Maker: _____

Relationship to Client: _____

Telephone: _____ *(home/cell/work/other)*

Fax: _____ Consent to leave detailed voicemail: ☐ Yes ☐ No

Address: _____
(Street, Town, Province, Postal Code)

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.

Is the client aware of this referral: ☐ Yes ☐ No Is the client agreeable to this referral: ☐ Yes ☐ No

Is the Substitute Decision Maker agreeable to this referral: ☐ Yes ☐ No

Please note, the Client or the Substitute Decision Maker, if applicable, must consent to a referral being made to the Community Treatment Order Program.

Income Information

Source of Income: ☐ CPP ☐ Employment Insurance ☐ ODSP ☐ Ontario Works ☐ Pension ☐ Savings ☐ No Income ☐ Other: _____

Medications - Required ☐ attached

*Please list medications (dose and frequency) that you would like to be included as a **requirement** of the CTO.*

Is the client on any long-acting injections? ☐ Yes ☐ No

If yes, who will be responsible for administration: _____

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Inpatient Psychiatric Hospitalization History - Required

Is the client currently admitted to hospital: ☐ Yes ☐ No

Diagnosis: _____

If yes, 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

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

If yes, please specify: _____

_____

To meet eligibility criteria, please list date(s) of previous psychiatric hospitalizations and length of stay within the last three years:

_____

_____

History of Previous Community Treatment Orders - Required ☐ attached

Issue / Renewal Number	Date CTO was Issued *(DD/MM/YYYY)*	Issuing Physician

Physician or Psychiatry Supports - Required

Issuing Physician or Psychiatrist: _____

Telephone: _____ Fax: _____

Monitoring Physician or Psychiatrist: _____ ☐ Same as above

Telephone: _____ Fax: _____

What is the expected frequency of visits with the monitoring Physician or Psychiatrist?

☐ Once per month ☐ Every three months ☐ Other: _____

Community Supports

Please indicate which supports you would like included as a requirement of the CTO.

1. Organization / Individual Name: _____

Describe Involvement: _____

_____

What is the expected frequency of visits with the service provider?

☐ Weekly ☐ Bi-weekly ☐ Once per month ☐ Other: _____

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2. Organization / Individual Name: _____

Describe Involvement: _____

_____

What is the expected frequency of visits with the service provider?

☐ Weekly ☐ Bi-weekly ☐ Once per month ☐ Other: _____

_____

Primary Care Provider/Psychiatrist Name

_____ _____

Primary Care Provider/Psychiatrist Signature **Date** *(DD/MM/YYYY)*

Thank you for making a referral to the HPHA Community Treatment Order 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 Central Intake at **519-272-8210 extension 2570** or **by fax 519-272-8226**