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.

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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 range 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: _____

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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 ☐ No

If 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: _____

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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)*: _____

_____

_____

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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.

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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.**