Huron Perth Seniors Mental Health and Addictions Response Team Referral Form

The Huron Perth Seniors Mental Health and Addictions Response Team provides mobile Behavioural Supports Ontario (BSO) services for residents of Huron and Perth Counties living with chronic and persistent mental health concerns, addictions, and/or responsive behaviours associated with dementia and/or neurocognitive conditions.

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 Huron Perth Seniors Mental Health and Addictions Response Team at 519-527-8421 extension 4818 or by fax 519-527-8420.

Information for Individuals Being Referred

- The individual being referred and/or Substitute Decision Maker/Caregiver must be aware that a referral is being made to the Huron Perth Seniors Mental Health and Addictions Response Team
- Appointment booking will be communicated via telephone to the client and/or Substitute Decision Maker/Caregiver and/or via fax to the referral source
- If an individual’s contact information changes, they and/or Substitute Decision Maker/Caregiver are responsible to notify the program or their Mental Health Clinician.
- Huron Perth Seniors Mental Health and Addictions Response Team staff will make three attempts to contact the individual/ Substitute Decision Maker/Caregiver by telephone. If contact cannot be made, the file will be closed and the referral source will be notified.
- Individuals can contact the Huron Perth Seniors Mental Health and Addictions Response Team to receive an update on the status of their referral by calling 519-527-8421 extension 4818.

How to Submit the Huron Perth Seniors Mental Health and Addictions Response Team Referral Form

- Please fax the completed Referral Form to **519-527-8420** (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.

Note: The Huron Perth Seniors Mental Health and Addictions Response Team will notify the Referral Source in writing that the referral forms are incomplete and/or illegible, and provide the Referral Status of Pending Due to Incomplete Documentation notification. The Referral Source will be asked to submit any missing information within **21 days** in order for the referral to be processed by the Huron Perth Seniors Mental Health and Addictions Response Team. If the required information is not received by this date, **the referral will be closed;** you are welcome to re-refer the individual in future. Re-referrals will be processed by the date that the completed package is received, **not the date of initial inquiry**.

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 Huron Perth Seniors Mental Health and Addictions Response Team at 519-527-8421 extension 4818.

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

☐ 65 years of age living with chronic and persistent mental health concerns, addictions, or responsive behaviours associated with dementia and/or neurocognitive conditions
☐ Under 65 years of age with a cognitive impairment
☐ Resident of Huron or Perth County

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: ______________________________
(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: ______________________________

Living Arrangements *(self, spouse, long-term care, retirement home, group home, etc.)*: ______________________________

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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: ________________________

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Substitute Decision Maker / Caregiver Information – 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 on their behalf. The HPHA will refrain from communicating Personal Health Information until consents are verified.

When scheduling initial assessment, make arrangements with:

☐ Client **OR** ☐ Primary Power of Attorney (POA) / Substitute Decision Maker *(if checked, please indicate below)*

Name of Substitute Decision Maker / Caregiver: ______________________________

Relationship to Client: ______________________________

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

Consent to leave detailed voicemail: ☐ Yes ☐ No

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

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:

☐ Cognitive Assessment
☐ Behavioural Management Plan
☐ Medication Review
☐ Mental Health Needs Assessment and Treatment
☐ Transition Support to Long Term Care/Retirement Home for Clients at Risk of Being Declined Due to Complex Behaviours
☐ Other: ______________________________

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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)*

- ☐ Physical Expressions of Risk *(throwing, hitting, kicking, biting, etc.)*
- ☐ Verbal Expression of Risk *(profanity, name calling, crying, moaning, screaming, etc.)*
- ☐ Sexualized Expression of Risk *(disrobing, exposing self, groping others, inappropriate comments, lewd sexual talk, etc.)*
- ☐ Motor Expressions *(pacing rummaging, fidgeting, etc.)*
- ☐ Suicidal Behaviour / Self Harm — Plan: ☐ Yes ☐ No
- ☐ Wandering/Elopement
- ☐ Resistant or Refusing Behaviour *(refusing medication, bathing, dressing, etc.)*
- ☐ Mood Changes
- ☐ Medication Compliance
- ☐ Impaired Memory
- ☐ Sleep Disturbances
- ☐ Self-Neglect
- ☐ Safety Concerns
- ☐ Having Delusions *(believing others are out to get them or taking their belongings, feelings of self-importance)*
- ☐ Impaired Judgement/Insight
- ☐ Experiencing Hallucinations *(visual, auditory, etc.)*
- ☐ Falling — Number of falls in last 6 months ________
- ☐ Suspiciousness/Paranoia
- ☐ Hospitalization or Emergency Department visits in past 6 months
- ☐ Difficulty with ADL/IAD
- ☐ Substance Use
- ☐ Alcohol Use

Is there a history of violence: ☐ Yes ☐ No

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.

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

Please attached relevant notes, assessments, consults.

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Supplemental Information

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

☐ Medical/Psychological/Psychiatric History
☐ Hospital Discharge Summaries
☐ Psychiatric Hospitalization(s)
☐ Urinalysis (R&M, C&S)
☐ Chest X-Ray
☐ CT Head Scan
☐ ECG
☐ MMSE/MOCA
☐ DOS Charting (1-2 weeks)
☐ Consult Notes
Laboratory Results (within the last 3 months): ☐ CBC ☐ Electrolytes ☐ Calcium ☐ Phosphorus
☐ Glucose ☐ TSH ☐ Vitamin B12/Folate ☐ Liver Functions
☐ Other Assessments (e.g. GDS, PHQ-9, GAD-7): ______________________________

Has a delirium been ruled out for this client: ☐ Yes ☐ No

Have you made other referrals to other programs / services: ☐ Yes ☐ No

If yes, please specify: ______________________________

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

______________________________ ______________________________
Signature *(PCP, Clinician, Self or Caregiver)* **Date** *(DD/MM/YYYY)*

Thank you for making a referral to the Huron Perth Seniors Mental Health and Addictions Response 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 the Huron Perth Seniors Mental Health and Addictions Response Team at **519-527-8421 extension 4818** or **by fax 519-527-8420**