



**Alexandra Marine & General Hospital  
Huron Perth Clinical  
Intensive Case Management  
Referral Form**



All Sections of this form are to be filled out in order proceed with referral

<b>Date:</b>		<b>Health Card#</b>		<b>Version:</b>	
<b>Name:</b>			<b>Gender:</b> <input type="checkbox"/> M <input type="checkbox"/> F		<b>Marital Status:</b>
<b>Mailing Address:</b>			<b>Physical Address:</b>		
<b>Postal Code:</b>					
<b>Mail Correspondence accepted:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			<b>Birth date:</b>		<b>Age:</b>
<b>Telephone Numbers (Primary):</b>			<b>(Secondary):</b>		
<b>Messages can be left?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			<b>Messages can be left?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Emergency Contact:</b>			<b>Relationship:</b>		
<b>Address:</b>			<b>Telephone Number:</b>		
<b>Family Physician:</b>			<b>Psychiatrist:</b>		
<b>Phone #:</b>			<b>Phone #:</b>		
<b>Allergies:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, specify:					
<b>Are there any barriers to accessing service?</b> (Language, communication, physical, visual etc.)?		<input type="checkbox"/> Yes <input type="checkbox"/> No : <b>If yes, specify:</b>			
<b>Referral Source:</b>			<b>Agency:</b>		
<b>Phone:</b>		<b>Is individual aware of this referral?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Previous client of CPS/ICM?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>How long ago?</b>			
<b>Does individual receive any services from the following? ( please check all that apply)</b>					
<input type="checkbox"/> CMHA Huron Perth		<input type="checkbox"/> Choices for Change			
<input type="checkbox"/> CMHA Middlesex (WOTCH)		<input type="checkbox"/> Women's Shelter			
<input type="checkbox"/> Grief Counselling (Huron Hospice)		<input type="checkbox"/> Family Health Team Social Work			
<input type="checkbox"/> Psychologist		<input type="checkbox"/> Huron Perth Centre for Children and Youth			
<input type="checkbox"/> Other _____					
<b>Previous OCAN assessment completed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, do we have permission to access it?</b>					
<b>Are there any safety risks staff should be aware of in delivering service?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>If yes, specify:</b>					
<b>Reasons for Referral:</b>					

**Symptoms:**

**Psychiatric Diagnosis, by whom and when:**

**Current Medications and Dosages:**

**HOSPITALIZATIONS FOR PSYCHIATRIC REASONS**

Dates and lengths of each hospitalization, to either general or psychiatric hospital for psychiatric reasons

Dates	Length of Stay	Hospital	Reason for admission

**Number of visits to an emergency department for psychiatric reasons in the past six months** \_\_\_\_\_

**History**                      No      Yes      When      Comments

History	No	Yes	When	Comments
Suicidal Attempts				
Other self Harm behaviours				

**FUNCTIONAL ABILITIES**

**Yes**

**No**

**Unknown**

Does individual have safe Housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does individual maintain vocational activity (school, volunteer, employment)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does individual have family and/or social network involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can individual carry out daily routines/chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does individual struggle with substance use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

**RISK ISSUES**

Are there any legal aspect to this referral with:      **CAS**       **Lawyer**       **Probation**       **Parole**       **Police**

If yes, specify:

Has the individual ever engaged in episodes of harm to people or damage to property (fire setting, vandalism etc)

**YES**       **NO**       If yes, specify:

**Criminal Charges**

No

Yes

Charge

When

Disposition & Comments

Current Charges	<input type="checkbox"/>	<input type="checkbox"/>			
Past Charges	<input type="checkbox"/>	<input type="checkbox"/>			

**Individual given Huron Perth Helpline and Crisis Response Team phone number:**  Yes       No      #1-888-829-7484

**Form Completed by:** \_\_\_\_\_.

Fax the COMPLETED Form to 519-524-9349.