



**INPATIENT/OUTPATIENT REFERRAL
ASSERTIVE COMMUNITY
TREATMENT/TOLDO
NEUROBEHAVIOURAL INSTITUTE**

Name: _____

D.O.B.: _____ (MM/DD/YYYY)

Health Card#: _____

- Assertive Community Treatment (ACT)
Please fax completed referrals to 519-254-2433
- Toldo Neurobehavioural Institute (TNI)
Prior to faxing– please call Intake Nurse at 519-257-5111 Ext. 77835
Send completed referrals to Intake fax number 519-257-5210

Referral Source Information

Referral Source: It is expected that patient will be returned to the care of community psychiatrist upon discharge from ACT/TNI

Date of Referral: _____ Contact Name: _____

Referring Agency: _____ Referring Psychiatrist: _____

Phone Number: _____ Fax Number: _____

Reports Required	Enclosed	Reports Required	Enclosed
Psychiatric Admission Consult		Psychological Evaluation/Testing	
Past Psychiatric Consults		Social Work Assessment/Report	
History and Physical		Occupational Therapy Report	
MHA Forms		Current Labs	
MAR		Psychiatric Discharge Summary cc'd to ACT/TNI	

SECTION A: REFERRING PSYCHIATRIST TO COMPLETE

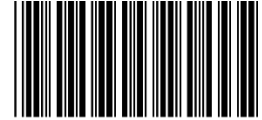
DSM V Diagnosis	Describe current signs and symptoms
Principle Diagnosis	
Additional Diagnoses	
Psychosocial and Contextual Factors	
Functional Assessment (WHODAS 2.0)	
Progress during current course of treatment and significant treatment failures/successes: _____	

Purpose of referral and goals for treatment in ACT/TNI	
1. _____	



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2. _____
3. _____



4251HD

Client Name: _____

SECTION B: COMMUNITY INFORMATION

Residential Status

- Private Home / Apt. Assisted Living / Group Home Long Term Care Facility
 Hospital (psychiatric) Hospital (non-psychiatric) Homeless

Can client return to residence post discharge? Yes No

If in hospital, is this person designated as Alternative Level of Care? Yes No

Income

- Employment Social Assistance (OW) ODSP Employment Insurance
 Family No Source of Income Pension CPP Other: _____

Outpatient Supports – Physician and Community Agency Involvement

Family Physician: _____ Telephone: _____
 Community Psychiatrist: _____ Telephone: _____
 ACT/TNI – Name: _____ Telephone: _____
 CMHA – Name: _____ Telephone: _____
 Other – Name: _____ Telephone: _____

SECTION C: CURRENT LEGAL INFORMATION (MHA, Consent & Capacity)

If client is in hospital, is the client **Voluntary** or **Involuntary**

- Form I Issue Date: _____ Expiration Date: _____
 Form III Issue Date: _____ Expiration Date: _____
 Form IV Issue Date: _____ Expiration Date: _____

Is the client capable to consent to treatment? Yes No

If no, SDM/POA: _____ Telephone: _____

Date of most recent capacity assessment for treatment: _____ (MM/DD/YYYY)

Is client capable to consent to manage finances? Yes No

If no, SDM/POA: _____ Telephone: _____

Date of most recent capacity assessment for finances: _____ (MM/DD/YYYY)

Is the client currently on a Community Treatment Order? Yes No
(If yes, attach a copy of the Community Treatment Plan)

Is there a Consent and Capacity Board Hearing pending for the client? Yes No

Is the client currently facing legal charges? Yes No

Is Mental Health Diversion involved with this client? Yes No



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Any past history of legal involvement?

Yes No

If yes, provide details: _____

Client Name: _____

SECTION D: CONCURRENT DISORDER HISTORY

Is there a diagnosis of Substance-Related or Addictive Disorders?

Yes No

Substance use (type, frequency):

Substance use treatment history and current treatments: _____

Opioid Replacement Therapy, Opioid Agonist Therapy

Yes No

Prescriber Information: _____

Additional dosing and pharmacy information: _____

Behavioral Addiction

Yes No

Please describe:

**SECTION E: HISTORY OF MOST RECENT PSYCHIATRIC HOSPITALIZATIONS
(INCLUDING CURRENT)**

Admission Date	Hospital	LOS



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History of ECT: Yes No Details:

SECTION F: RISKS – CURRENT / HISTORICAL

	Yes	No	If yes, when?	Details
Violent/Aggressive Behaviour	<input type="checkbox"/>	<input type="checkbox"/>		
Restraint Needed	<input type="checkbox"/>	<input type="checkbox"/>		
Elopement Attempts/Risk	<input type="checkbox"/>	<input type="checkbox"/>		
Suicidal Attempts	<input type="checkbox"/>	<input type="checkbox"/>		
Self-harming Behaviour	<input type="checkbox"/>	<input type="checkbox"/>		
Sexual Aggression	<input type="checkbox"/>	<input type="checkbox"/>		
Hoarding Behaviour	<input type="checkbox"/>	<input type="checkbox"/>		
Fire Setting	<input type="checkbox"/>	<input type="checkbox"/>		
Other, please specify:	<input type="checkbox"/>	<input type="checkbox"/>		

Client Name: _____

SECTION G: CLIENT GOALS FOR TREATMENT

Client Identified Goals for Treatment

1.

2.

3.