HÔTEL-DIEU
ESTD GRACE 1888
HEALTHCARE

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. _____

INPATIENT/OUTPATIENT REFERRAL
ASSERTIVE COMMUNITY TREATMENT/
TOLDO NEUROBEHAVIOURAL INSTITUTE

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

INPATIENT/OUTPATIENT REFERRAL
ASSERTIVE COMMUNITY TREATMENT/
TOLDO NEUROBEHAVIOURAL INSTITUTE

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

INPATIENT/OUTPATIENT REFERRAL
ASSERTIVE COMMUNITY TREATMENT/
TOLDO NEUROBEHAVIOURAL INSTITUTE

History of ECT: ☐ Yes ☐ No Details:

SECTION F: RISKS – CURRENT / HISTORICAL

	Yes	No	If yes, when?	Details
Violent/Aggressive Behaviour	☐	☐		
Restraint Needed	☐	☐		
Elopement Attempts/Risk	☐	☐		
Suicidal Attempts	☐	☐		
Self-harming Behaviour	☐	☐		
Sexual Aggression	☐	☐		
Hoarding Behaviour	☐	☐		
Fire Setting	☐	☐		
Other, please specify:	☐	☐		

Client Name: _____

SECTION G: CLIENT GOALS FOR TREATMENT

Client Identified Goals for Treatment
1.
2.
3.