



**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 519-254-2443
- Toldo Neurobehavioural Institute
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 IV Diagnosis	Which is primary? (✓ box)	Describe current signs and symptoms
Axis I		
Axis II		
Axis IV		
Axis V (current GAF)		

Progress during current course of treatment and significant treatment failures/successes: _____

Purpose of referral and goals for treatment in ACT/TNI

1. _____
2. _____
3. _____





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SECTION D: ADDICTION HISTORY

Check all areas of current substance abuse/dependence:

- Alcohol
- Inhalants
- Hallucinogens
- Cocaine or crack
- Stimulants – e.g. amphetamines
- Opiates (including synthetics) – e.g. heroin, methadone
- Cannabis
- Prescription medication
- Injected drug use
- Gambling
- Sex

Additional details of substance misuse/treatments: _____

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

Admission Date	Hospital	LOS

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"/>		





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SECTION G: CLIENT GOALS FOR TREATMENT

Client Identified Goals for Treatment

1.

2.

3.

