INPATIENT REFERRAL
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 TNI

Date of Referral: __________________________ Contact Name: __________________________

Referring Agency: __________________________ Referring Psychiatrist: __________________________

Phone Number: __________________________ Fax Number: __________________________

Reports Required

Reports Required

<table>
<thead>
<tr>
<th>Psychiatric Admission Consult</th>
<th>Enclosed</th>
<th>Psychological Evaluation/Testing</th>
<th>Enclosed</th>
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<tbody>
<tr>
<td>Past Psychiatric Consults</td>
<td></td>
<td>Social Work Assessment/Report</td>
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<tr>
<td>History and Physical</td>
<td></td>
<td>Occupational Therapy Report</td>
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<tr>
<td>MHA Forms</td>
<td></td>
<td>Current Labs</td>
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<td>MAR</td>
<td></td>
<td>Psychiatric Discharge Summary cc’d to TNI</td>
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SECTION A: REFERRING PSYCHIATRIST TO COMPLETE

DSM IV DiagnosisWhich 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 to TNI / Goals for treatment in TNI

1. __________________________________________

2. __________________________________________

3. __________________________________________
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 – 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
Any past history of legal involvement? □ Yes □ No

Has the client been found Not Criminally Responsible (NCR) on Account of Mental Disorder? □ Yes □ No
If client has any legal involvement, provide details: ________________________________________________
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Client Name: ________________________________

**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 abuse/treatments: ____________________________________________

**SECTION E: HISTORY OF MOST RECENT PSYCHIATRIC HOSPITALIZATIONS**

(INCLUDING CURRENT)

<table>
<thead>
<tr>
<th>Admission Date</th>
<th>Hospital</th>
<th>LOS</th>
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History of ECT: ☐ Yes ☐ No Details: ________________________________

**SECTION F: RISKS – CURRENT / HISTORICAL**

<table>
<thead>
<tr>
<th>Violent/Aggressive Behaviour</th>
<th>Yes</th>
<th>No</th>
<th>If yes, when?</th>
<th>Details</th>
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<tbody>
<tr>
<td>Restraint Needed</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Elopement Attempts/Risk</td>
<td>☐</td>
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<tr>
<td>Suicidal Attempts</td>
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<td>Self-harming Behaviour</td>
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<td>Sexual Aggression</td>
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<td>Hoarding Behaviour</td>
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<td>Fire Setting</td>
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<td>Other, please specify:</td>
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### SECTION G: CLIENT GOALS FOR TREATMENT

<table>
<thead>
<tr>
<th>Client Identified Goals for Treatment</th>
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<tbody>
<tr>
<td>1.</td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
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