



Assertive Community Treatment Team of
Stormont Dundas Glengarry & Akwesasne

Common Referral Form

WELCOME!

Please ensure that you have completed the accompanying screening tool to ensure that the applicant qualifies for this service.

We want to process this application as quickly as possible (notification of admittance/declined service within 30 days of receipt provided sufficient information is supplied upon first submittal). In order for us to do so, please also answer as many questions as you can in each of the following sections and include as many of the additional support documents as possible requested on the last page. Please have client participate in completing this common referral form, if possible.

Please **PRINT** in **black** ink or type all answers. Should you have any questions or require assistance with filling in this form, please call **(613-361-6363 ext. 8790)** and a staff person will be happy to help you.

Mail or fax the completed application form to the address and fax number below.

Assertive Community Treatment Team (Stormont, Dundas, Glengarry and Akwesasne)
(Equipe Communautaire de Traitement Intensif)
850 McConnell Avenue
Cornwall, ON K6H 4M3

Tel: 613-361-6363 ext. 8790

Fax: 613-361-6364 Attention ACTT

Toll free/Sans frais: 1-844-631-6363



A/ Personal and Contact information

Applicant Information:

Legal First Name: _____ Legal Last Name: _____

Applicant's name (if different from above): _____

D.O.B. (yyyy/mm/dd): _____ Age: _____

Sex: Male Female X

Pronouns: He/Him Her/She They/Them X

OHIP Number (if known): _____ Version Code: _____ Expiry (yyyy/mm/dd): _____

Primary address: _____

Apt. No: _____ City: _____ Province: _____ Postal code: _____

If No Fixed Address, Please provide possible location where the applicant might be found: _____

Preferred Contact #: _____ Can a confidential message be left at this number? Yes No

If the applicant does not have a phone or is otherwise difficult to reach, is there someone with whom he or she is in regular contact that we can call in order to reach him or her?

Name: _____ Telephone No.: _____ Extension: _____

Relationship to applicant: _____

Can a message be left at the phone number provided? Yes No

Does the applicant have a Substitute Decision-Maker for treatment (SDM)? Yes No

If yes, please provide their name, address and contact information:

Does the applicant have a Trustee for finance? Yes No

If yes, please provide their name, address and contact information:

Does the applicant have a Power of Attorney? Yes No

If yes, please provide their name, address and contact information:



Does the applicant speak English: Yes No Some

What is the applicant's first language(s): English French Other _____

What is the applicant's preferred language: English French Other _____

We are working to ensure that our services are being developed in a manner that serves all the communities living in our boundaries. The following question is voluntary and answering it will not affect the application.

What is the applicant's ethnicity and/or culture (i.e. what culture or ethnicity do they identify with)?

Culture/Ethnicity: _____ Citizenship/Immigration status: _____

B/ REFERRAL SOURCE INFORMATION (Please complete if not a self-referral)

Referrer's name & Title: _____ Agency: _____

Telephone # _____ Fax# _____

Street Address: _____ Apt./Suite No.: _____

City: _____ Province: _____ Postal code: _____

Relationship to Applicant: _____

Is the applicant aware of this referral? Yes No

Have you completed an Ontario Common Assessment of Need (OCAN) in the past 6 months with the applicant?

Yes No Don't know / not sure

C/ CURRENT STATUS

Who does the applicant presently live with? Please check all boxes that apply:

Self Spouse/partner Spouse/partner & others

Parents Relatives Non-Relatives

Children (Age/Sex) _____

Is the applicant currently homeless or at risk of becoming homeless?

Yes No Somewhat If Yes or Somewhat, please explain: _____

What type of housing does the applicant presently live in?

- | | |
|--|---|
| <input type="checkbox"/> Approved Homes & Homes for Special Care | <input type="checkbox"/> Private House/Apt.- Client Owned /Market |
| <input type="checkbox"/> Correctional/Probationary Facility | <input type="checkbox"/> Rent |
| <input type="checkbox"/> Domiciliary Hospital | <input type="checkbox"/> Private House/Apt.- Other/Subsidized |
| <input type="checkbox"/> General Hospital | <input type="checkbox"/> Retirement Home/Senior's Residence |
| <input type="checkbox"/> Psychiatric Hospital | <input type="checkbox"/> Rooming/Boarding House |
| <input type="checkbox"/> Other Specialty Hospital | <input type="checkbox"/> Supportive Housing – Congregate Living |
| <input type="checkbox"/> No fixed address | <input type="checkbox"/> Supportive Housing – Assisted Living
(RTF 24 Hr Home and Group Homes) |
| <input type="checkbox"/> Hostel/Shelter | <input type="checkbox"/> Private Non-Profit Housing |
| <input type="checkbox"/> Long-Term Care Facility/Nursing Home | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Municipal Non-Profit Housing | |

What is the applicant's primary source of income?

- | | |
|---|---|
| <input type="checkbox"/> ODSP | <input type="checkbox"/> Social Assistance (e.g. Ontario Works) |
| <input type="checkbox"/> Employment | <input type="checkbox"/> Employment Insurance |
| <input type="checkbox"/> Pension | <input type="checkbox"/> Disability Assistance |
| <input type="checkbox"/> Family | <input type="checkbox"/> No Source of Income |
| <input type="checkbox"/> CPP/OAS (Old age security) _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> GIS (Guaranteed income supplement) | |

What is the applicant's current employment status?

- | | | |
|--|--|--|
| <input type="checkbox"/> Independent/Competitive | <input type="checkbox"/> Assisted/Supportive | <input type="checkbox"/> Alternative Business |
| <input type="checkbox"/> Sheltered Workshop | <input type="checkbox"/> Non-paid Work Experience | <input type="checkbox"/> No Employment – Other Activity |
| <input type="checkbox"/> Casual/Sporadic | <input type="checkbox"/> No Employment of Any Kind | <input type="checkbox"/> Unknown or Service Recipient Declined |

What is the highest grade/level of education the applicant has attained? _____

What is the applicant's current education status?

- | | | | |
|--|--|---|--------------------------------|
| <input type="checkbox"/> Not in School | <input type="checkbox"/> Elementary/Junior High School | <input type="checkbox"/> Secondary/High School | <input type="checkbox"/> Other |
| <input type="checkbox"/> Trade School | <input type="checkbox"/> Vocational Training Centre | <input type="checkbox"/> Adult Education | |
| <input type="checkbox"/> Community College | <input type="checkbox"/> University | <input type="checkbox"/> Unknown/Service Recipient Declined | |

D/ HEALTH INFORMATION

- Is the applicant capable to consent to treatment?** Yes No Unknown
- Is the applicant capable to consent to collection/use/disclosure of PHI?** Yes No Unknown
- Is the applicant capable to manage property?** Yes No Unknown

How long has the applicant been experiencing mental health difficulties (i.e. length of time)?

What is the applicant's mental health diagnosis? Please be as specific and detailed as possible.



What was the age of onset of this diagnosis? _____

What was the age of the first hospitalization for mental health reasons? _____

Has the applicant been to hospital (Emergency Room visits and/or in-patient stays) due to mental health challenges in the last two years? Yes No Unknown

Please provide an estimate of the total number of days that they have spent in Hospital In-Patient Units, due to mental health difficulties, within the past two years: _____ days (estimate if need be)

Please list the hospitals the applicant has been in and the dates of the visit:

<u>Hospital</u>	<u>Day/Month/Year to Day/Month/Year</u>
_____	_____
_____	_____
_____	_____

Is the applicant in hospital now due to mental health issues? Yes No
If yes, what is the anticipated date of return to community living? _____

Is the applicant currently on a Community Treatment Order (CTO)? Yes No

Does the applicant have a psychiatrist? Yes No
If yes, please provide the following information on the psychiatrist:

Name: _____ Telephone #: _____

Do you have a physician (e.g. GP, family doctor, walk-in clinic doctor)? Yes No
If yes, please provide the following information on the physician:

Name: _____ Telephone #: _____

- Concurrent Disorders (substance use and mental illness) Yes No Unknown
- Dual Diagnosis (developmental disability and mental illness) Yes No Unknown
- Neurological (head/brain Injury, epilepsy, Parkinson's, cognitive disorders etc.) Yes No Unknown
- Other chronic illness/ physical disabilities (e.g. hypertension, diabetes, allergies) Yes No Unknown

If YES to any of the above, please describe:

Please complete the following list for all current medications being used:



Drug Name	Dose	Start Date	Side Effects Experienced	Comments/Notes:

Please complete the following list for all Mental Health medications used in the past:

Drug Name	Dose	Start/End Date	Side Effects Experienced	Reasons Stopped

E/ APPLICANT'S SUPPORT NEEDS

Applicant is requesting support with:

- Managing specific symptoms of serious mental health illness
- Developing daily living skills
- Finances
- Educational opportunities
- Housing needs
- Occupational/Employment/Vocation
- Substance abuse/addictions issues
- Relationships
- Legal issues
- Social
- Peer supports
- Other: _____

Referral source comments regarding the applicant's support needs:

Please briefly describe the reason(s) for referral. What is the present difficulty and in which areas could the applicant benefit from support?



We ask the following questions to determine if there are any safety or risk issues of which we should be aware. Answering any of the questions below will NOT exclude the applicant from service. Please include when, how many incidents, how severe and the outcome:

History of self-harm or suicide threats or attempts:

History of substance use or treatment:

History of aggressive behavior or violence (verbal, physical, sexual):

History of destruction of property (including fire-setting):

History of any other risk or safety issue:

Is the applicant currently or has been involved in the past with the criminal justice system? (Please note, this will NOT affect the applicant's ability to receive services. It is to help us better direct the application)

Yes No Don't know

If yes, please indicate dates, types of involvement and outcome:

- | | |
|---|---|
| <input type="checkbox"/> Bail order | <input type="checkbox"/> Parole |
| <input type="checkbox"/> ORB (Ontario Review Board) | <input type="checkbox"/> Court diversion |
| <input type="checkbox"/> Probation | <input type="checkbox"/> Incarceration |
| <input type="checkbox"/> Restraining orders | <input type="checkbox"/> NCR (Not criminally responsible) |

Outcome (s):

F/ EXISTING SUPPORTS



Is the applicant currently working with any other service providers? Yes No Don't know

If yes, please provide the following information on each service provider with whom the applicant is working:

Agency	Name/Contact Person	Service(s) Received	Telephone Number

Please describe the informal supports (e.g. family, friends, faith community, cultural groups/community, other community supports) in the applicant's life and how satisfied they are with each of these supports.

G/ PAST SUPPORTS

Has the applicant worked with any other service providers in the past? Yes No Don't know

If yes, please provide the following information on each service provider with whom they worked:

Agency	Name/Contact Person	Service(s) Received	Telephone Number



H/ SUPPORTING DOCUMENTATION

In order for us to process this referral within 30 days, it is essential that we receive as much of the following documentation as is available to you:

- Hospital Discharge Summaries (complete history as available)
- Hospital Documentation (from last 3 months only)
 - Case reviews
 - Nursing notes
 - Treatment plan(s)
- Specialty and/or specialist assessments (complete history as available)
- Disposition Orders
- CTOs (Community Treatment Orders)
- CPIC (Canadian Police Information Check)
- ACTT Referral Screening Tool (mandatory)
- Related Legal Documentation

APPLICANT AND REFERRER'S DECLARATION & CONSENT

Consent forms allowing communication between the referral source and the Assertive Community Treatment Team has been included? Yes No

I have discussed this referral with the applicant and the applicant agrees with the submission of this referral.

Referrer's signature: _____ **Date:** _____

***Applicant's signature:** _____ **Date:** _____

Substitute Decision Maker (SDM) signature: _____ **Date:** _____

*Not necessary to process the application.