WRHN
Waterloo Regional Health Network

OFFICE USE ONLY
Date Referral Received: _____
Received by: _____
Feedback to referring agency: ☐ Yes ☐ No
Referral Complete: ☐ Yes ☐ No
If no, please return to referring agency with request to complete.

Specialized Mental Health Referral

3570 King St. E., Kitchener, Ont. N2A 2W1

Date of Referral (MM/DD/YYYY): _____

Referral Source
Referring Physician: _____
Agency: _____
Contact Name: _____
Phone Number:_____

Please Affix Patient Label

Eligibility Criteria: Please ensure and check off that patient meets all criteria

_ Resident of Waterloo Wellington (Kitchener, Waterloo, Cambridge, Guelph, Wellington, Wellesley, Wilmot, and Woolwich areas)
Is 18 years or older
Has been diagnosed with either a schizophrenia spectrum / other psychotic disorder OR a severe depressive OR bipolar disorder
Above diagnosis is the predominant presentation that referral is being made for
The individual has not responded to recent standard therapeutic trial of pharmacological interventions, intensive outpatient supports, and/or acute hospital inpatient interventions
Is not currently designated as ALC
Obtaining housing or disposition planning is not the primary reason for referral

If accepted, at time of transfer patients must have been out of any form of Psychiatric Intensive Care for 14 days AND be medically stable.

The referrals process:

- Completed referral packages will be reviewed with the Intake Committee and we will notify the referrer of the decision within seven calendar days. Referrals are to be submitted by Monday at 4 p.m. for those referrals requiring a prompt response.
- It is expected that patients who are waiting for admission after acceptance will continue to receive active treatment and disposition planning
- For questions please call: (519) 749-4300, ext. 7472 (Program Secretary) or ext 7053 (Intake Coordinator)
- Fax completed referrals to the attention of the Intake Coordinator, Specialized Mental Health Fax number: (519) 894-8308

Incomplete or missing information will delay the decision making process

Client Name: _____

SECTION A - Client Information

Name: MRN:

Address:

Phone Number: Home: Work:

Health Card Number: Version Code: Expiry:

Any known allergies? ☐ Yes ☐ No If yes, please specify:

Date of Birth (MM/DD/YYYY): Age: Gender:

Emergency Contact: _____ Relationship to Client: _____
Phone Number: Home:_____ Work: _____

If accepted, is client in agreement with admission to Specialized Mental Health? ☐ Yes ☐ No

If accepted, is SDM in agreement with admission to Specialized Mental Health? ☐ Yes ☐ No ☐ N/A

Is client currently in hospital? ☐ Yes ☐ No

If no, where is client being referred from? _____

If yes, date of Admission: (MM/DD/YY): _____

If in hospital, does this person meet the criteria for Alternate Level of Care (ALC)? ☐ Yes ☐ No

Number of emergency room visits for **mental health** in past two years: _____

Please list location and dates of psychiatric hospitalizations in the past: (attach sheet if more space is required)

SECTION B – Treatment Plan & Goals, Specific Details are required

Current Treatment Plan (i.e. medication plans, assessments, community referrals, etc.)

Patient Admission Goals (i.e. mental health, vocational, housing, etc.)

Team Admission Goals (i.e. mental health, vocational, housing, etc.)

Client Name: _____

SECTION C – Current & Past Diagnoses

	Yes	Current	Details:
Psychotic Disorders			_____
Bipolar Disorders			_____
Depression Disorders			_____
Trauma & Stressor Related Disorders			_____
Personality Disorders			_____
Substance & Addictive Disorder			_____
Neurocognitive Disorders			_____
Other			_____

Has psychological testing been completed? ☐ Yes (please attach to referral) ☐ No

SECTION D – Risks: Current & Historical

Is there a history?	Details (when, what happened, severity, etc.)
Violent / Homicidal Behaviour	_____
Fire Setting	_____
Self-harming Behaviour	_____
Sexual Aggression	_____
Suicidal Behaviour	_____
Elopement	_____
Hoarding Behaviour	_____
Other (please specify):	_____

SECTION E – Community Information

Residential Status

☐ Private Home/Apt ☐ Assisted Living / Group Home ☐ Long Term Care Facility

☐ Hospital (psychiatric) ☐ Hospital (non-psychiatric) ☐ Homeless

Are there barriers to the client returning post discharge? ☐ Yes ☐ No

If yes, please describe: _____

Current Community Supports (Specify):

Family Physician:	_____	Telephone:	_____
Psychiatrist:	_____	Telephone:	_____
Mental Health Supports:	_____	Telephone:	_____
Other:	_____	Telephone:	_____

Referrals (AIS, FACTT, ACT) and Status of applications:

Client Name: _____

SECTION F – Current Legal Information (MHA, Consent & Capacity)

If client is in the hospital, is the client under Mental Health Act? ☐ Yes ☐ No

If Yes, Current Form:_____ Expiry Date: _____

Is the client capable to consent to treatment? ☐ Yes ☐ No

If no, SDM: _____ Tel: _____

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

Is client capable to manage property? ☐ Yes ☐ No

If no, SDM:_____ Tel: _____

Date of most recent capacity assessment for property, if assessed (MM/DD/YY): _____

Legal

Is the client currently on a Community Treatment Order? ☐ Yes ☐ No

Is there a consent and capacity board pending for this client? ☐ Yes ☐ No

If client has any legal involvement, please provide details: (i.e. pending court dates, current status, etc.)

SECTION G – Treatment (Psychiatric and Non-Psychiatric)

Is the most recent MAR attached? ☐ Yes ☐ No

Is medication taken as prescribed? ☐ Yes ☐ No Details: _____

Is assistance needed to take medication? ☐ Yes ☐ No Details: _____

Is there a history of client choosing to decline prescribed medications? ☐ Yes ☐ No

Details: _____

What is the level of observation/frequency of monitoring required? Please provide rationale.

Has chemical, physical, environmental restraint or psychiatric intensive care been used during past month? If client required PICU, please specify how many times during this admission and for how long? ☐ Yes ☐ No

Details:

Client Name: _____

SECTION H – Substance Use

Please check all that apply and <u>underline</u> predominant substance of concern:

☐ Nicotine ☐ Alcohol ☐ Cannabis ☐ Opiates
☐ Inhalants ☐ Cocaine or crack ☐ Benzodiazepines
☐ Hallucinogens ☐ Crystal Meth ☐ Other: _____

How long since last use?
☐ < 24 Hours ☐ 1 – 3 Days ☐ Within last week
☐ Within last month ☐ More than 1 month

Withdrawal symptoms ☐ Yes ☐ No
If yes, please describe: _____

Process addiction? ☐ Yes ☐ No
If yes, please describe: _____

Prescribed medication for treatment of substance use? ☐ Yes ☐ No
If yes, please describe: _____

SECTION I – Current Medical Conditions & Concerns

☐ COPD, Asthma or recent respiratory infection ☐ Diabetes ☐ MRSA, ESBL, Hep C
☐ Neurological Condition, Seizure Disorder ☐ Head injury ☐ Falls Risk
☐ Hyperlipidemia, CAD ☐ Osteoporosis
☐ Other: _____

Weight: _____ Height: _____ Special Diet: _____
Last chest x-ray: _____
Last CT scan: _____
Last MRI: _____

SECTION J – Functional Ability

Does the client have any difficulties or require support with any of the following:

☐ Money Management ☐ Personal Hygiene ☐ Transportation
☐ Communication ☐ Blindness/Vision impairment ☐ Learning disability
☐ Deafness/Hearing Loss ☐ Cognitive impairment ☐ Incontinence
☐ Meal Preparation ☐ Other: _____

Ambulation: ☐ Independent ☐ Assisted ☐ Dependent

Transfers: ☐ Independent ☐ Assisted ☐ Dependent

Wheelchair: ☐ Yes ☐ No

Equipment used for ADLs / mobility: