DISTRICT OF NIPISSING
COMMUNITY MENTAL HEALTH AND ADDICTIONS
LONG TERM SUPPORT SERVICES

COMMON REFERRAL FORM

Assertive Community Treatment Teams 1 and 2,
North Bay Regional Health Centre
ACTT 1 Phone 705-494-3031 Fax 705-494-3019
ACTT 2 Phone 705-494-1069 Fax 705-494-8447

Addiction and Supportive Housing
Case Management
North Bay Recovery Home
Phone 705-472-2873 Fax 705-472-6442

Case Management Program
Centre Alliance Centre,
West Nipissing General Hospital
Phone 705-753-2271 Fax 705-753-4202

Intensive Case Management,
East Nipissing Mental Health Services
Phone 705-744-5511x229 Fax 705-744-5088

Intensive Case Management Program,
Nipissing Mental Health Housing
and Support Services
Phone 705-476-4088 Fax 705-495-3585

Peer Support (Outreach) Services
People for Equal Partnership in Mental Health (PEP)
Phone 705-494-4774 Fax 705-494-4775

Voluntary Trusteeship and Outreach Supports,
Canadian Mental Health Association,
Nipissing Regional Branch
Phone 705-474-1299 Fax 705-474-5325

This Form is used in the District of Nipissing by the services of the agencies listed above in order to receive and make referrals. The Form is intended to help find the best place for you among the agencies providing long term community mental health and addiction services at the time of contact. It is not intended to assess your situation or act as an intake. You can complete the Form yourself or someone can help you complete it.

You only need to complete one Common Referral Form. Please print or write clearly. The Form can also be completed electronically **but it still has to be printed off and signed**.

Please complete the Form as fully and accurately as possible. The Triage Team needs this information to make sure that the best referral is made for you in the shortest time possible. Check with one of the groups or agencies shown above if you need an explanation or more information.

If, after reviewing your referral, the Triage Team determines that none of the listed services are suitable to your stated needs, **your initials in the box at the bottom of page 5 (the last page of the form) will indicate your desire to have your Referral forwarded to a service that may better suit your needs.**

When complete, please send all five pages of the Form to any of the above listed agencies in your area.

Date of Referral (numerically): ____ | ____ | ____ (e.g., 15|09|42)
Day Month Year

A Identifying Information for Person Being Referred

Name: ______________________ Date of Birth(numerically): _____|_____|_____
Day / Month / Year

Gender______ Age ______ Aboriginal ______Non Aboriginal ______ Health Card # ______________________

Preferred Language: English ☐ French ☐ Other: ______________________

Language 1st Spoken: English ☐ French ☐ Other: ______________________

Language still understood: English ☐ French ☐ Other: ______________________

Address of residence: ______________________

____

______________________ Postal Code: ______________________

Mailing Address (if different from above): ______________________

____

______________________ Postal Code: ______________________

Phone Number: (home) ______________________ (work) ______________________

Alternate Contact name and number: ______________________

____

Currently incarcerated in Correctional Facility ☐ Y ☐ N

Current Family Physician: ______________________ Is your physician aware of this referral? ☐ Y ☐ N

Current Psychiatrist: ______________________

B Referral Source Information

Can we contact your Referral Source? ☐ **Y** ☐ **N**

Name of Person Making Referral: ______________________

Referral Source: ______________________ Phone Number: ______________________

Address: ______________________

______________________ Postal Code: ______________________

Services **Currently** in Place: **(Please list specific services beside agency name)**

ACTT 1 ______________________ ☐
ACTT 2______________________ ☐
Addiction and After-Care Services (Please Specify) ______________________ ☐
CMHA______________________ ☐
Centre Alliance Centre ______________________ ☐
East Nipissing Mental Health Services ______________________ ☐
Nipissing Mental Health Housing & Support Services ______________________ ☐

Name: ____________________ Date of Birth: ____________________

People for Equal Partnership in Mental Health (PEP) ____________________ ☐
Mental Health Clinic ____________________ ☐
Community Care Access Centre ____________________ ☐
Probation and Parole ____________________ ☐
Other: (Please Specify) ____________________ ☐

C Psychiatric Information

Psychiatric Diagnosis: Primary: ____________________

Secondary: ____________________

Who provided you with this diagnosis? ____________________

Dates and length of each hospitalization, to either general or psychiatric hospitals, **for psychiatric reasons**: (most recent to oldest) Please attach sheet if needed.

Date(s) (mm/yy)	Length of Stay	Name and Location of Hospital

Number of visits to an emergency room, **for psychiatric reasons**, in the past six months:	

Actual duration of psychiatric illness is more than ten years ☐ Y ☐ N

Anticipated duration of psychiatric illness is more than ten years ☐ Y ☐ N

Psychiatric illness has resulted in difficulties that interfere with capacity to function in one or more major life activities ☐ Y ☐ N

Have you completed an **OCAN** (Mental Health Assessment) within the last (6) six months? ☐ Yes ☐ No

If yes, where? ____________________

Name: ______________________ Date of Birth: ______________

D Addiction Information

Are you living with an addiction? ☐ Y ☐ N

If your answer is **yes**, please continue to complete this section.
If your answer is **no**, skip to Section E

When was your last ADAT completed? (Addiction Assessment Tool)

Day	Month	Year

(e.g., 15|09|42) ☐ N/A

Where was your last ADAT completed?

Organization or institution: ______________________ Phone: ______________

Address: ____

____

Dates, lengths, and locations of treatment for addiction:

Date(s) (mm/yy)	Length of Stay	Name and Location of Treatment Facility

Number of visits to an emergency room or detoxification facility **for addiction reasons**, in the past six months:	

E Medications (all prescribed medications, psychiatric and non-psychiatric), dose and frequency *note: please include any over-the-counter products (e.g., Tylenol, Gravol) and/or alternative medications (e.g., St. John's Wort) the applicant is using*

Name: ______________________________ Date of Birth: ______________________

F Reason for Referral/Assistance Needed

Please make sure there is an X showing how often assistance is needed marked for each row.	**Daily** (including after hours)**(X)**	**Lots** (at least 2-3 times/ week)**(X)**	**Some** (weekly or less) (X)	**None (X)**
Assistance with Medication Issues **(please specify below**)**				
Reducing impact of psychiatric symptoms				
Maintaining needed medical & psychiatric care (remembering appointments, following through on plan of care, etc.)				
Assistance with physical health issues				
Problem substance use				
Maintaining appropriate housing				
Remaining appropriately engaged with educational programs				
Remaining appropriately employed				
Support/advocacy with pending/current criminal charges				
Remaining appropriately engaged in self help programs ie: Alcoholics Anonymous, Narcotic Anonymous				
Maintaining needed supportive counselling				
Living skills (cooking, personal care, etc.)				
Other (specify)				
Other (specify)				

Specialized Support Service Needs:	**(X)**
Voluntary Trusteeship	
Peer Support (Outreach) Services	

G Other

(Other information you think is important that could help in the decision of which service this referral should go to including current issues and primary reason for referral)

**** Please also use this space to specify the kind of help needed with medications:**

Name: ______________________________ Date of Birth: ____________________

H Release of Information

PLEASE PAY PARTICULAR ATTENTION TO THIS SECTION OF THE FORM.

The purpose of this Form is to provide information to the Common Referral Triage Table to identify the long term support service that is best suited to your needs. The Triage Table may need to contact any programs identified on this Form that you are already receiving service from. Once the Triage Table has identified the service that is most appropriate for your situation, they will need to release a copy of this Form to that service. By signing this Form, you are agreeing that the information it contains can be used by the Triage Table in this way. As well,

- This Form will only be used in this way for ninety (90) calendar days after the date that you sign it (below). After ninety calendar days, if you still need service, you will need to complete a new release form.
- When the Triage Table communicates with you to advise you of which service will be contacting you about your referral, they will also contact the individual or agency that sent this Form (referral source) to inform them of what referrals were made.

Date: ____________________

Name of Applicant (or Substitute Decision-maker) (printed): ____________________

Signature: ____________________________________

If you have made your mark above rather than signing, or if a Substitute Decision-maker has completed this Form, please have the mark/signature witnessed:

Date: ____________________ Witness' Name (printed): _______________________

Witness' Signature: ____________________________

If, after reviewing your referral, the Triage Team determines that none of the listed services are suitable to your stated needs, your initials in this box will indicate your desire to have your Referral forwarded to a service that may fit your needs better.