Alexandra Marine & General Hospital
Community Mental Health Referral Form

ESSENTIAL CRITERIA FOR CPS & CICM REFERRAL

Individual appears to have a **severe and persistent mental illness** defined by the Ministry of Health as:

Diagnosis *such as schizophrenia, major affective disorders, personality disorders, paranoid and other psychoses should be present or person demonstrates a pattern of behaviours that indicate a severe and persistent mental illness*

Disability *refers to the fact that the disorder interferes with the person's capacity to organize and complete the activities of daily living*

Duration *may be based on a severe first episode or a chronic nature of the illness.*

Individual is 16 years of age or over. Individual has a functional impairment in more than one skill area: daily living, social, educational, vocational. Individual is willing and prepared to attend.

Date:	**CPS** ☐ **or CICM** ☐	**Health Card#**	**Version**:
Name:		**Gender**: ☐ M ☐ F	**Marital Status**:
Address: **Mail Correspondence accepted**: ☐ Yes ☐ No		**911 Address**:	
Postal Code:		**Birth date**:	**Age**:
Telephone Number (Home): **Messages can be left?** ☐ Yes ☐ No		(cell/work/other): Messages can be left? ☐ Yes ☐ No	
Emergency Contact:		Relationship:	
Address:		Telephone Number:	
Family Physician: **Phone #**:		**Psychiatrist**: **Phone #:**	

Allergies: ☐ **Yes** **No** ☐ **If yes, specify:**

Are there any barriers to accessing service (Language, communication, physical, visual etc.)?	☐ Yes ☐ No : **If yes, specify:**
Referral Source:	**Agency**:
Phone:	**Is individual aware of this referral**? ☐ Yes ☐ No
Previous client of CPS/ICM? ☐ Yes ☐ No	**How long ago**?

Does individual receive any services from the following? (please check all that apply)

- ☐ **CMHA Huron Perth**
- ☐ **CMHA Middlesex (WOTCH)**
- ☐ **Grief Counselling (Huron Hospice)**
- ☐ **Psychologist**
- ☐ **Other** _____
- ☐ **Choices for Change**
- ☐ **Women's Shelter**
- ☐ **Family Health Team Social Work**
- ☐ **Huron Perth Centre for Children and Youth**

Previous OCAN assessment competed? ☐ Yes ☐ No **If yes**, do we have permission to access it?

Are there any safety risks staff should be aware of in delivering service? ☐ Yes ☐ No

If yes, specify:

Reasons for Referral:

Symptoms:

Psychiatric Diagnosis, by whom and when:

Current Medications and Dosages:

HOSPITALIZATIONS FOR PSYCHIATRIC REASONS

Dates and lengths of each hospitalization, to either general or psychiatric hospital for psychiatric reasons

Dates	Length of Stay	Hospital	Reason for admission

Number of visits to an emergency department for psychiatric reasons in the past six months _____

History	No	Yes	When	Comments
Suicidal Attempts				
Other self Harm behaviours				

FUNCTIONAL ABILITIES	Yes	No	Unknown
Does individual have safe Housing	☐	☐	☐
Does individual maintains vocational activity (school, volunteer, employment)	☐	☐	☐
Does individual have family and/or social network involvement	☐	☐	☐
Can individual carry out daily routines/chores	☐	☐	☐
Does individual struggle with substance use	☐	☐	☐
Comments:			

RISK ISSUES

Are there any legal aspect to this referral with: **CAS** ☐ **Lawyer** ☐ **Probation** ☐ **Parole** ☐ **Police** ☐

If yes, specify:

Has the individual ever engaged in episodes of harm to people or damage to property (fire setting, vandalism etc)

YES ☐ **NO** ☐ If yes, specify:

Criminal Charges	No	Yes	Charge	When	Disposition & Comments
Current Charges	☐	☐			
Past Charges	☐	☐			

Individual given Huron Perth Helpline and Crisis Response Team phone number: ☐ Yes ☐ No #1-888-829-7484

Fax the COMPLETED Form to 519-524-9349.