Canadian Mental Health Association
Champlain East
Mental health for all

Association canadienne pour la santé mentale
Champlain Est
La santé mentale pour tous

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REFERRAL AND REQUEST FOR COMMUNITY MENTAL HEALTH SERVICES

Please use this form to refer an individual/client to CMHA-Champlain East Services. If you need assistance in completing the form, contact our Information and Referral Line by calling 613-933-5845 or 1-800-493-8271.

Community Support Services Offered:

- Intensive Case Management (ICM)
- Court Programs (Pre-Charge, Support, Diversion and Post-Court)
- Vocational Support
- Hoarding Program
- Housing Supports
- Community Homes for Opportunity (CHO)
- Social Recreation Program

Essential Criteria:

- 16 years of age or older
- Resident of the Champlain East area (Stormont, Dundas, Glengarry, Prescott and Russell and Akwesasne)
- Severe and persistent mental illness or symptoms of
- Must be voluntary

Ministry of Health Definition of Severe and Persistent Mental Illness

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.

Note: All requirements listed above must be met in order to be considered for our Community Support Services

Secondary Criteria: (These indicators are not essential but reinforce the need for intensive case management)

- Homeless or at risk of becoming homeless
- Imminent loss of major supports and or being socially isolated (i.e. Family)
- Functional impairment in several areas: daily living skills, social skills, educational/vocational, financial,
- Service is needed to maintain recent rehabilitation gains (i.e., from supportive housing or hospital services)
- Presence of concurrent disorders
- Presence of a dual diagnosis

For Community Homes for Opportunity (CHO) Referral:

- Require housing and support services to live as independently as possible.
- Require some assistance with activities of daily living (personal care, housekeeping, health care, medication assistance, etc.)
- Require some level of support on a 24-hour basis.

CMHA does NOT:

- **Accept** Housing Funding only applications
- **Accept** Involuntary Clients
- **Complete** Psychiatric Assessments
- **Triage** Urgent/Crisis Applications

REFERRAL FORM

Client Personal Information:

Name: _____

Address: _____ City: _____

Province: _____ Postal Code: _____

Date of Birth: m ____ / d ____ / y _____

Phone: _____ Permission to leave message ___Yes ___ No

Alternate Phone: _____

Email Address: _____ Permission to send email ___Yes ___ No

Gender: ___ Male ___ Female ___ Other: _____

Preferred Language: ___ English ___ French ___ Other: _____

Mother Tongue: _____

Military Service: _____ Active _____ Retired

Aboriginal Origin: ___ Aboriginal ___ Non-Aboriginal ___ Unknown

Aboriginal Identity: ___ First Nations ___ Inuit ___ Metis ___ Non Status ___ Urban

Ontario Health Card #: _____

Does the client require any accessibility supports? (i.e.: literacy, mobility, hearing, vision, support animals) ___ Yes ___ No

If yes, please describe the type of support needed:

_____

_____

_____

_____

Primary diagnosis: _____ **Secondary diagnosis: _____**

Is the client experiencing psychosis? ___Yes ___ No

1st Experience with psychosis? ___Yes ___ No

Other Illness / Disability:

- Concurrent Disorder (substance dependence with mental illness)
- Dual Diagnosis (developmental impairment with mental illness)
- Other: _____

Does the client have a primary care provider (Dr. / NP)? ___ Yes ___ No

Name: _____ Phone number:_____

Does the client have a psychiatrist? ___ Yes ___ No

Name: _____ Phone number: _____

Date of most recent psychiatric hospitalization: m ____ / d ____ / y ____

Reason for Admission:

_____

_____

_____

Mental Health Risk Factors:

- To what degree is the client's daily function impaired by their symptoms? __Mild __Moderate __Severe
- Is excessive recreational drug, alcohol use, or gambling a concern? __ Yes __No
    - Is there current involvement with an addictions treatment program? __ Yes __No
    - Is there involvement with a methadone program? __ Yes __No
- Has the client had suicidal thoughts in the past month? __ Yes __No
    - Has a plan to suicide? __ Yes __No
    - Has attempted to suicide in the past month? __ Yes __No
    - Is client engaging in self-harm? __ Yes __No
- Does the client have a history of aggressive or destructive behavior? __ Yes __No
- Does the client have a history of criminal legal charges? __ Yes __No
- Does the client have current criminal charges? __ Yes __No Next Court Date: __/__/__
- Is the client currently homeless or at risk of becoming homeless? __ Yes __No
- Are family / relationship issues affecting the client's mental health? __ Yes __No

Reason for Referral:

- Specific symptoms of mental illness: _____
- Suicidal Ideation or attempts: ___ Yes ___ No ___ Unsure
- Education & Supporting coping with their illness: _____
- Substance Abuse supports & linkages: _____
- Experiencing mental illness, current criminal charges (not in custody): ___ Yes ___ No ___ Unsure
- Requesting Housing support: ___ Yes ___ No
- Other reasons:

    _____

    _____

    _____

Are you referring this individual to any other services at this time? ___ Yes ___ No

Are there any additional support/services currently being accessed in the community? Provide details below:

Agency	Type of Service	Contact Person/Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please provide additional supporting documents to support the request for services (i.e.: Gain, OCAN, psychiatric notes etc.)

Referral Source:

Referred by: _____ Date: d ___ / m ___ / y ___

Relationship: _____

Address: _____

Phone #:_____

Has client been made aware of this referral? ___ Yes ___ No

_____ _____

Signature of Referral Source Date

Privacy Information

Personal information gathered by our Branch is kept in confidence. Our personnel are authorized to access, use and disclose personal information for the purpose of acceptance into the CMHA Mental Health Services, case coordination and referral, as well as treatment planning. Safeguards are in place to ensure that the information is not disclosed or shared more widely than is necessary to achieve the purpose for which it was gathered. We also take measures to ensure the integrity of this information is maintained and to prevent its being lost or destroyed.

For more information visit our web site www.cmha-east.on.ca or contact our Chief Privacy Officer at 613-933-5845.