Service Request Form

please COMPLETE FORM and fax to ONE of the referring agencies

1) Hamilton Assertive Community Treatment Teams (ACTT) — tel: 905-528-5354 — fax: 905-528-8442

2) Intensive Case Management Access Coordination (IntAc) — tel: 905-528-0683 — fax: 905-546-0055

NOTE: Please call IntAc directly for Street Outreach referrals

3) Schizophrenia Outpatient Clinic (SOC) — tel: 905-522-1155 x 39044 — fax: 905-527-7301

Service Request Type: **PLEASE CHECK ONE**

- ☐ 1. ACTT *include admission/discharge summaries & social work history form last hospital admission*
- ☐ 2. IntAc
  - ☐ Street Outreach (client is homeless)
  - ☐ Intensive Case Management
- ☐ 3. SOC
  - ☐ Diagnostic Consult
  - ☐ Medication Consult
  - ☐ Psychiatric Follow-up

** = must complete

Clinician: **
currMdName

Date of Referral: **
currentDate.default

Client Information

Name: **	DOB: (YYYY MM DD)	Age:	Gender: **	Martial Status:	
patName	...tBirthdate.yyyysmmsdd	...hics.Age	patSex		☐ Aboriginal ☐ Non-Aboriginal

Health Card #: patHN

VC: patVersionCode

Address / Emergency Shelter / Last Location Seen: **
patAddressLabel

Phone #: ** *If available*
patHomePhone.default

Emergency Contact Information: ** *If available*

Does client have a physical disability? ** ☐ Yes ☐ No
If yes, explain:

Physical Description for Client: ** *for Street Outreach Only*

Can client speak/understand English? ** ☐ Yes ☐ No

Is there a Community Treatment Order (CTO)? ☐ Yes ☐ No

ORB involvement? ☐ Yes ☐ No

Is the client in the HOMES Program? ☐ Yes ☐ No

Referral Source

Self Referral? ** ☐ Yes ☐ No *If no* Is client aware of referral? ** ☐ Yes ☐ No

Name: **
currMdName

Position Title:

Agency Name: ** *If applicable*

Phone: ** *If applicable*	Ext:	Fax:
currMdPhone.default	currMdPhone.ext	currMdFax.default

Referral Source (role, frequency, length of time involved and client's response): ** *If applicable*

Do staff need to be aware of any past or current saftey or behavioural issues when apporaching the client ** *If yes, explain:* ☐ Yes ☐ No

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Referral Source *cont'd*

Diagnosis:
Axis 1:

Axis 2:

Axis 3:

Has the client been referred within the past 6 months? ☐ Yes ☐ No *If yes* to which agency:

Are you referring the client to other agencies? *If yes* please explain:

Rationale for level of service 1

Has the client provided verbal permission to contact his/her clinician? ☐ Yes ☐ No ☐ N/A

Specialists or Other Agencies Involved *(include past mental health services)*

Indicate involvement with any of the following:
- ☐ counselling services
- ☐ vocational services
- ☐ probation / parole
- ☐ addiction services
- ☐ Children's Aid Society
- ☐ housing program
- ☐ other *(specify)*

Comments

Family Physician		**Psychiatrist**	
Name: patMdName	Phone: currMdPhone.default	Name:	Phone:
Office Address: patMdAddrLabel		Office Address:	
Is family physician aware of referral? ☐ Yes ☐ No Is he/she willing to work with ACTT/IntAc/SOC? ☐ Yes ☐ No		Is psychiatrist aware of referral? ☐ Yes ☐ No Is he/she willing to work with ACTT/IntAc/SOC? ☐ Yes ☐ No	

Current Supports / Contacts *(professional and family)*

Name:	Relationship:	Phone:

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Current and Past Legal History

Is the client currently on probation/parole? ☐ Yes ☐ No *If yes* followed by: _____

Was client previously on probation/parole? ☐ Yes ☐ No *If yes* followed by: _____

Current and Past Psychiatric History *(please check and make comments where relevant)*

☐ SUICIDE HISTORY

☐ AGGRESSIVE BEHAVIOUR

☐ SUBSTANCE ABUSE

☐ HOSPITALIZATIONS

☐ COMMUNITY TREATMENT ORDER

Please indicate all those that apply:

- ☐ finances
- ☐ housing, household managment, evictions
- ☐ family relationships
- ☐ interpersonal skills
- ☐ personal care
- ☐ medication compliance
- ☐ follow-up compliance
- ☐ school/vocational activities
- ☐ social/leisure activities
- ☐ literacy
- ☐ language
- ☐ other *(specify)*

EMPLOYMENT current status:

EDUCATION highest level:

Please indicate all those that apply:

- ☐ violence toward self
- ☐ violence toward others
- ☐ violence toward property
- ☐ sexual assault
- ☐ head injury
- ☐ developmental delay *(neuropsychological testing is required)*
- ☐ fire setting
- ☐ other *(specify)*

Please indicate all those that apply:

- ☐ high risk or recent history of criminal justice involvement
- ☐ would require institutional placement without intensive support
- ☐ severe or intractable major symptoms
- ☐ otherwise unable to participate in office-based services
- ☐ 60 or more days in hospital OR five or more ER visits OR three or more hospitalizations in last year
- ☐ coexisting substance abuse disorder

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Current and Past Medical History

Current Medications *(please attach list)*

pat.Patient_Profile.Rx/Meds/Treatments.current_meds

Document Allergies

pat.Patient_Profile.ALLR/Allergies/Allergies

Rehabilitation Goals

Goals identified by client:

Comments

please provide any other relevant information as needed:

Please complete for referrals to SOC only:

currMdName

Referring Physician name (please print)

Referring Physician Signature

currMdPhysNum

Billing #