Alexandra Marine & General Hospital

Mental Health Outpatient Referral Form

Clinical Intensive Case Management and Huron Community Mental Health Services

Our service is unable to provide support in an emergency. If your client is experiencing a mental health crisis and requires immediate help, advise them to contact the Huron Perth Helpline and Crisis Response Team at 1-888-829-7484, or go to the nearest emergency department.

Important Information:

- This referral is NOT for psychiatry. To refer to a psychiatrist, please contact the department of psychiatry with Alexandra Marine & General Hospital at 519-524-8323 ext. 5361 or 5388.
- All sections of this form must be complete in order to proceed with the referral and the individual being referred must be aware that a referral is being made to Outpatient Mental Health Services.
- Referrals can be faxed to 519-524-9349. Incomplete referrals will be sent back to the referent.

Program referring to:

☐ **HCMHS:** Huron Community Mental Health Services welcomes individuals from Huron County, 16 years of age and over seeking treatment for their mental health. Individual and group treatment services are offered in our Goderich, Wingham, Clinton, Exeter and Seaforth offices.

☐ **CICM:** Clinical Intensive Case Management services provide time limited, goal-specific in-home community treatment in Huron & Perth Counties. The program focusses on relapse prevention & stabilization in the community utilizing psychological education, medication management, liaising with partner agencies & advocacy.

Referral Checklist - HCMHS:	**Referral Checklist – CICM:**
☐16 years of age or older ☐Ready/willing to engage in goal-oriented therapy ☐ Aware clients may be asked to engage in group treatment ☐Experiencing moderate to severe mental health challenges ☐Resident of Huron County ☐Able to attend regular appointments ☐***Aware clients may be asked to explore/access mental health supports through EAP, private benefits, and/or Family Health Team***	☐16 years of age or older ☐Ready/willing to engage in time-limited goal specific treatment ☐Experiencing serious mental health challenges ☐Resident of Huron or Perth Counties

Demographic Information

Legal Name: ______________________________ Gender: _________ Pronouns:_________

Preferred Name:______________________________ Birth Date: ________________________

Date:________________________ Health Card #:______________________________ Version:__________

Contact Information

Contact Number: ______________________________ Consent to leave detailed voicemail ☐

Mailing address: ______________________________ Consent to contact by mail ☐

Email address: ______________________________Consent to provide appt reminder by email ☐

Emergency contact: ______________________________ Consent to contact ☐

Relationship and Phone Number:______________________________

Reason for Referral

Please describe the reasons for the referral including presenting concerns, frequency and duration of symptoms, psychosocial factors and what lifestyle, behavioural, cognitive or emotional changes they would like to make regarding their mental health. Please indicate self-identified goals of care. Attach if details cannot fit in space provided:

Referral Source

Name: ____ Organization: ______________________________

Telephone: ___________________ Fax: __________________ Will you continue to provide care?: ________

Supports

Psychiatrist:____

Telephone: _______________________________________ Fax: __________________________________

Primary Care Provider: ____

Clinic: ___________________________ Telephone: _____________________ Fax: ___________________

Other Provider: ____

Clinic: ___________________________ Telephone: _____________________ Fax: ___________________

Other formal or informal supports: ____

Mental Health

Psychiatric Diagnosis, if known: ____

Past suicide attempts/self-harming:____
____

Hospital Presentations

For mental health related reasons, please provide dates and details:

Medical History

Describe any relevant medical issues that impact mental health:

Please list any allergies:____

Barriers to Treatment

Describe any vision, hearing, mobility, transportation, or stigma related barriers to treatment:

For CICM Specific Referrals

Are there any environmental concerns to be aware of in the home (e.g. pets/animals; smoking, others residing in the home, etc.)? *Please note we ask that clients do not smoke/vape during appointments*

Substance Use

Do drugs or alcohol interfere with your ability to engage in the following?

ADL's: ☐ Social Life: ☐ Work: ☐ Home Life: ☐

Details (e.g. indicate substance used, medication misuse, treatments engaged in, history and last use):

Protective Factors

List any known protective factors (i.e. steady employment, stable housing, supportive relationships, engagement in services, involvement in prosocial recreational activities):

Previous Law Enforcement/Legal Involvement and Safety

Current Charges: Yes ☐ No ☐ Unknown ☐ Details:____

Past Charges: Yes ☐ No ☐ Unknown ☐ Details:____

No Contact Orders: Yes ☐ No ☐ Unknown ☐ Details:____

On Probation or Parole: Yes ☐ No ☐ Unknown ☐ Details:____

Past Charges Dismissed/Diversion Completed: Yes ☐ No ☐ Unknown ☐ Details:____________________________

Any episodes of harm towards others? Yes ☐ No ☐ Unknown ☐ Details:___________________________________

Any episodes of property damage? Yes ☐ No ☐ Unknown ☐ Details:______________________________________

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

Details:

Are there any specific details that we should be aware of to help us create a safe space for this person?