ACTT - Referral & Screening Form

PRIVATE AND CONFIDENTIAL

1 844 437 3247
(HERE247)
Call anytime to access
Addictions, Mental Health
& Crisis Services
Waterloo-Wellington-Dufferin

I. DEMOGRAPHICS

Date of Referral: _____

Primary Referral Source:

Name: _____ Title: _____

Agency: _____

Address: _____

_____

Telephone: _____ Fax: _____

CLIENT INFORMATION:

Name: _____
(surname, first name)

Gender: Male ☐ Female ☐ **CID:**

Age: _____ Date of Birth: _____ _____ _____
(year) (month) (day)

Address: _____

_____

Telephone: _____

O.H.I.P. #: _____

Type of Current Housing

☐ Shelter ☐ Family ☐ Correctional Facility ☐ Friends ☐ Hospital-involuntary
☐ Hospital-voluntary ☐ Nursing Home ☐ Other (specify): _____

Source of Income:

☐ Employment F/T ☐ Employment P/T ☐ Family ☐ C.P.P. (Pension)
☐ Social Assistance ☐ O.D.S.P. (Disability) ☐ Other (specify): _____

Is client competent to consent to treatment? ☐ Yes ☐ No

Power of Attorney ☐ Yes ☐ No

If yes: Name: _____ Address: _____

Is client competent to consent financially? ☐ Yes ☐ No

Power of Attorney ☐ Yes ☐ No

If yes: Name: _____ Address: _____

Marital Status:

Single Common-Law Married Separated Divorced Widowed

Number and ages of children:

1. _____
2. _____
3. _____
4. _____

II. DISORDER/DIAGNOSIS

Primary Psychiatric Diagnosis: Check all that apply

- ☐ Bi-Polar Disorder
- ☐ Schizophrenia
- ☐ Delusional
- ☐ Personality Disorder
- ☐ Other (specify): _____
- ☐ Delusional Disorder
- ☐ Psychotic Disorder
- ☐ Schizoaffective Disorder
- Mental Retardation

Other Diagnose(s): Check all that apply

- ☐ Alcohol use disorder – abuse or dependence
- ☐ Other substance use (specify) _____
- ☐ Developmental disability
- ☐ Physical illness/disability (specify) _____

III. SERVICE USAGE

Check all that apply:

- ☐ History of Hospitalization
- ☐ Need for residential care
- ☐ Persistent, severe major symptoms
- ☐ Outpatient Treatment Failures
- ☐ History of incarceration
- ☐ Repeated unlawful behaviour
- ☐ Other legal problems
- ☐ Frequent emergency room visits
- ☐ History of aggression
- ☐ History of parasuicidality (cutting)
- ☐ Homelessness
- ☐ Risk of homelessness
- ☐ History of suicidality

Currently involved with the legal system (specify details of charges):

_____

_____

Other service providers currently involved with the client, e.g., physicians (G.P., psychiatrist); psychologist; nurses; social workers; occupational therapists; support workers; case managers; outreach workers; attorneys/lawyers; probation officers; other _____

Name	Agency	Title	Phone/Fax #

Current Medications:

Name	Dosage	Frequency

IV. LEVEL OF FUNCTIONAL IMPAIRMENT

Check all that apply:

- ☐ Poor nutrition
- ☐ Difficulty maintaining/sustaining employment
- ☐ Poor health maintenance practices
- ☐ Difficulty with meal preparation
- ☐ Marked homemaking difficulties
- ☐ Parenting difficulties
- ☐ Difficulty with money management
- ☐ Lack of structure to day

V. REFERRAL

Current Presenting Problems: _____

_____

_____

_____

_____

Name: CID:

Required for screening - Please mail or fax these documents:

1. Outpatient record
2. Hospital discharge summaries
3. Record of emergency mental health visits
4. Any other relevant information (i.e., psychological testing)
5. Completed Consent Form.

Has this referral and potential assessment process been discussed with:

a) Client ☐Yes ☐No

b) Family ☐Yes ☐No

c) Other (specify): _____

Is the client willing to participate in the referral/assessment process: Yes No

Referral Source's Signature: _____ Date: _____

Client's Signature: _____ Date: _____

Please mail to:

- Homewood Health Centre – North Wellington & Dufferin ACTT
  160 St. David St. S., Fergus, ON N1M 2L3 Tel: 519-787-1800, Fax: 519-787-2015
- Homewood Health Centre - Guelph South Wellington ACTT
  153 Delhi Street, Guelph, ON N1E 4J3 Tel: 519-767-3575, Fax: 519-767-3576

ACTT Office Use Only

Criteria Met / Criteria Not Met

Signed: _____

Date: _____