GRAND RIVER HOSPITAL

OFFICE USE ONLY
Date Referral Received: _____
Received by: _____
Feedback to referring agency: □ Yes □ No
Referral Complete □ Yes □ No
If no, please return to referring agency with request to complete.

Specialized Mental Health Referral

Specialized Mental Health, GRT2 Grand River Hospital – Freeport Site
3570 King St East, Kitchener, Ontario N2A 2W1

Prior to faxing - please call the program secretary at (519) 749-4300 ext. 7472
Fax completed referrals to the attention of the Intake Coordinator, Specialized Mental Health Fax number: (519) 894-8308

Please note that incomplete or missing information will delay the decision making process

Date of Referral (MM/DD/YYYY): _____

Referring Source

Referring Physician: _____

Agency: _____

Contact Name: _____

Phone Number:_____ Fax Number: _____

SECTION A - Client Information
Name:
Address:
Phone Number: Home: _____ Work: _____
Health Card Number: Version Code: Expiry:
Any known allergies? ☐ Yes ☐ No Please list if yes, _____
Date of Birth (MM/DD/YYYY): _____ Age: _____ Gender: _____
Next of Kin / Emergency Contact: _____ Phone Number: Home: _____ Work: _____ Relationship to Client: _____
If accepted, is client in agreement with admission to Specialized Mental Health? ☐ Yes ☐ No If accepted, is SDM in agreement with admission to Specialized Mental Health? ☐ Yes ☐ No ☐ N/A

Client Name: _____

Is client currently in hospital? ☐ Yes ☐ No

If no, where is client being referred from? _____

If yes, date of Admission: (MM/DD/YY): _____

Age at first psychiatric hospitalization: _____

Number of emergency room visits for **mental health** in past two years: _____

Please list location and dates of psychiatric hospitalizations in the past: (attach sheet if more space is required)

_____
_____
_____

Residential Status

☐ Private Home/Apt ☐ Assisted Living / Group Home ☐ Long Term Care Facility

☐ Hospital (psychiatric) ☐ Hospital (non-psychiatric) ☐ Homeless

Are there barriers to the client returning post discharge? ☐ Yes ☐ No

If yes, please describe : _____
_____
_____

Please provide information regarding referrals and discharge plans that have been considered for this client or that have been completed?

_____
_____
_____
_____

If in hospital, does this person meet the criteria for Alternate Level of Care (ALC)? ☐ Yes ☐ No

Income

☐ Employment ☐ Social Assistance (OW) ☐ ODSP ☐ Employment Insurance

☐ Family ☐ No source of income ☐ Pension ☐ CPP ☐ Other _____

Current Community Supports (Specify):

Family Physician: _____ Telephone: _____

Community Psychiatrist: _____ Telephone: _____

Will the community psychiatrist continue to follow this client upon discharge from Specialized Mental Health?

☐ Yes ☐ No

Mental Health Supports: _____ Telephone: _____

Other - Name: _____ Telephone: _____

Client Name: _____

SECTION B – Current Legal Information (MHA, Consent & Capacity)

If client is in the hospital, is the client under Mental Health Act? ☐ Yes ☐ No

If Yes, Current Form: _____ Expiry Date:_____

Is the client capable to consent to treatment? ☐ Yes ☐ No

If no, SDM: _____ Tel: _____

Date of most recent capacity assessment for treatment (MM/DD/YY): _____

Is client capable to manage property? ☐ Yes ☐ No

If no, SDM: _____ Tel: _____

Date of most recent capacity assessment for property, if assessed (MM/DD/YY): _____

Legal

Is the client currently on a Community Treatment Order? ☐ Yes ☐ No
(If yes, please attach a copy of the Community Treatment Plan)

Is there a consent and capacity board pending for this client? ☐ Yes ☐ No

Is the client currently facing legal charges? ☐ Yes ☐ No

Has the client been found Not Criminally Responsible on Account of Mental Disorder; have a forensic history past or present? ☐ Yes ☐ No

If client has any legal involvement, please provide details: (i.e. pending court dates, current status, etc.)

_____
_____
_____

SECTION C – Current and Past Diagnoses

	YES	NO	CURRENT	If yes, please list
Psychotic Disorders	☐	☐	☐	_____
Bipolar Disorders	☐	☐	☐	_____
Depressive Disorders	☐	☐	☐	_____
Trauma & Stressor Related Disorders	☐	☐	☐	_____
Personality Disorders	☐	☐	☐	_____
Substance-Related& Addictive Disorders	☐	☐	☐	_____
Neurocognitive Disorders	☐	☐	☐	_____
Other	☐	☐	☐	_____
				_____

Has psychological testing been completed? ☐ Yes ☐ No **(** If yes, please attach a copy of the report)

Client Name: _____

SECTION D – Substance Use

Please check all that apply and underline predominant substance of concern:

☐ Nicotine (tobacco, e-cigarettes) ☐ Alcohol (beer, wine, liquor) ☐ Cannabis (marijuana, hash)

☐ Inhalants (glue, gasoline, paint thinner, keyboard cleaner, etc.) ☐ Cocaine or crack cocaine

☐ Hallucinogens (MDMA/Ecstasy, magic mushrooms, LSD, etc.) ☐ Opiates (prescription, heroin, opium)

☐ Amphetamines/methamphetamine ☐ Methadone ☐ Benzodiazepines

☐ Other: _____

Typical route of administration: ☐ Inhaling ☐ Smoking ☐ Injecting

Number of days used in the past 90 days :_____

How long since last use? ☐ <24 Hours ☐ 1 – 3 Days ☐ Within last week

☐ Within last month ☐ More than 1 month ago

Withdrawal symptoms ☐ Yes ☐ No

If yes, please describe:

_____

_____

Process addiction? ☐ Yes ☐ No

If yes: ☐ Gaming ☐ Sexual ☐ Gambling ☐ Other: _____

Current addiction treatment (counselling, AA, CD Specialist, etc.)

☐ Yes ☐ No

Details:_____

_____

Past substances of concern:

_____

_____

SECTION E – Medical

VITAL SIGNS

BP ____ HR ____ RR____ Temp____ O2 Saturation____ O2 Requirements____

HEIGHT ____ WEIGHT ____

Date:_____

☐ CAD ☐ Hyperlipidemia ☐ Diabetes

☐ Seizure Disorder ☐ Neurological Condition ☐ Osteoporosis

☐ COPD ☐ Diabetes ☐ Osteoarthritis

☐ HTN ☐ CHF ☐ Other _____

Client Name: _____

Last chest x-ray _____
Last CT scan _____
Last MRI _____
Last bone mineral density _____

Recent vaccinations ☐ Yes ☐ No
_____ Flu
_____ Pneumovax
_____ Other

SECTION F – Treatment (Psychiatric and Non-Psychiatric)

Is the most recent MAR attached? ☐ Yes ☐ No

Is medication taken as prescribed? ☐ Yes ☐ No Details: _____
_____

Is assistance needed to take medication? ☐ Yes ☐ No Details: _____
_____

Is there a history of client choosing to decline prescribed medications? ☐ Yes ☐ No
Details: _____
_____

What is the level of observation/frequency of monitoring required? Please provide rationale.
_____
_____

Has chemical, physical, environmental restraint or psychiatric intensive care been used during past month?
☐ Yes ☐ No Details: _____
_____

Is client able and willing to engage in individual therapy?
☐ Yes ☐ No Details:_____
_____

Is client able and willing to attend group therapies?
☐ Yes ☐ No Details:_____
_____

Client Name: _____

SECTION G – Risks: Currently/Historically

Is there a history?	Yes	No	If yes, when?	Comments
Violent Behaviour	☐	☐	_____	_____
Fire Setting	☐	☐	_____	_____
Suicidal Behaviour	☐	☐	_____	_____
Self-Harming Behaviour	☐	☐	_____	_____
Sexual Aggression	☐	☐	_____	_____
Homicidal Behaviour	☐	☐	_____	_____
Hoarding Behaviour	☐	☐	_____	_____
Other, please specify:	☐	☐	_____	_____

SECTION H – Functional Ability

Does the client have any difficulties or require support with any of the following:

☐ Money Management ☐ Homemaking ☐ Meal Preparation ☐ Transportation ☐ Personal Hygiene

☐ Non-ambulatory or assisted ambulation ☐ Blindness/Vision impairment ☐ Learning disability

☐ Language/Cultural ☐ Deafness/Hearing Loss ☐ Cognitive impairment

☐ Incontinence ☐ Head injury ☐ Seizures

☐ Speech impairment ☐ Other (specify) _____

Does this client require any assistive devices? If so, please specify:

_____

_____

SECTION I – Treatment Plan & Goals
Specific details are required

Current Treatment Plan (i.e. medication plans, assessments, community referrals, psychosocial, etc.)

_____

_____

_____

Patient/Client Admission Goals (i.e. mental health, vocational, housing, etc.)

_____

_____

_____

Team Admission Goals (i.e. mental health, vocational, housing, etc.)

_____

_____

_____

Client Name: _____

SDM/Family Admission Goals (if applicable)

_____
_____
_____

Social / Family / Collateral History (if available):

Support System (list providers, type, frequency and intensity of support):

Has the client been considered for other inpatient programs? ☐ Yes ☐ No

If yes, please describe: _____

Required Documentation to be attached:

☐ **ASSESSMENTS COMPLETED** (psychiatry, psychology, occupational therapy, social work, etc)

☐ **RECENT PROGRESS NOTES** (from past 2 weeks, can be from any discipline)

☐ **ADMISSION NOTE FROM MRP**

☐ **ER/CRISIS SERVICE NOTE**

☐ **MAR**

☐ **MOST RECENT PHYSICAL SCREENING,LABWORK & ASSOCIATED RESULTS/REPORTS**

☐ **OTHER RELEVANT INFORMATION** Please specify: _____

Client Name: _____

PHYSICAL EXAMINATION

SKIN Intact Not Intact

HEENT

Thyroid Exam	Details:
Tympanic membranes	Details:
Neck ROM Exam	Details:
Oral Exam	Details:
Cervical Lymph Nodes	Details:

CVS

Heart auscultation	Details:
Carotid bruits	Details:
Peripheral pulses	Details:
Peripheral edema	Details:

RESPIRATORY

Lungs auscultation	Details:

ABDOMEN

Bowel Sounds	Details:
Palpation	Details:
Liver	Details:

Neurological Exam

Cranial Nerve Exam	Details:
Motor Exam	Details:
Distal Sensory/Vibration Exam	Details:
Gait/Station Exam	Details:

GENITALIA/PELVIC/RECTAL EXAM

Not Indicated due to absence of symptoms

Indicated due to symptoms, Details:

SUPPLEMENTARY TESTING

MMSE score (if indicated, with appropriate documentation) _____

Labs only for positive findings:

CBC, Electrolytes, BUN, Creatinine

Urine and bld. for Toxicology

CXR

Pregnancy Test

I have performed the physical exam: _____

Physician/Nurse Practitioner Signature