

SUMMIT ACTT - REFERRAL FORM



| | | | |
|-------------------|-------|--------------|-------|
| Date of Referral: | _____ | Address: | _____ |
| Program: | _____ | City/Town: | _____ |
| Referred By: | _____ | Postal Code: | _____ |
| Phone: | _____ | Email: | _____ |

Demographic Data

| | | | |
|----------------|-------|---------------------|-------|
| Name: | _____ | Birth Date (y/d/m): | _____ |
| Address: | _____ | City/Town: | _____ |
| Postal Code: | _____ | Phone: | _____ |
| Health Card #: | _____ | Source of Income: | _____ |
| Physician: | _____ | Phone: | _____ |
| Psychiatrist: | _____ | Phone: | _____ |
| Next of Kin: | _____ | Phone: | _____ |
| SIN #: | _____ | Marital Status: | _____ |

Aware of Referral?

Client yes no **Family** yes no **Doctor** yes no

Current Diagnosis:

Current Status:

Inpatient voluntary Inpatient involuntary
Incarcerated
 Outpatient Community

Reason for referral/treatment request? Please list presenting issues and why ACT is being recommended now?

Other community supports/services currently in use:

Previous involvement with other programs:

Current barriers to discharge and follow up:

Has the client attempted to connect with traditional community mental health programs?

Has the client been homeless? If so, when and for how long?

History of psychiatric diagnosis:

Allergies:

Any medical or dental issues:

Current medication and treatment regime:

Any history or non-compliance to medication and/or treatment (Please describe in detail, including patient-reported reasons)?

Total number of psychiatric admissions: _____
Age of illness onset: _____
Age of first hospitalization: _____

Most recent psychiatric admissions:

| Facility: | Admission date: | Discharge date: |
|------------------|------------------------|------------------------|
|------------------|------------------------|------------------------|

Describe any alcohol and/or drug use:

Any history of seizures? yes no

Any history of abuse (child, emotional, physical and/or sexual)?

Is the client currently in an abusive situation?

Any homicidal or suicidal ideation (Please describe any past attempts and the precipitating events or triggers)?

Describe violent tendencies towards property/others/self (Any triggers also):

Describe any past or present involvement with the law:

Is the client on probation? If so, please provide contact information.

Number of times incarcerated in the last two years: _____

Please describe how the client functions in these areas:

Living situation:

Money management (including trustee contact information, if applicable):

Nutrition:

Self care/Activities of daily living (ADL):

Social/Leisure:

Education history and status:

Employment history and status:

Medication management:

Is the client treatment competent? yes no

SDM Name: _____ Phone: _____

Community Treatment Order (CTO)? yes no

Please include:

- Copies of the last three hospital Admission and Discharge Summaries
- Copies of psychological testing, OT assessments, social work assessments and any other applicable assessments or testing
- Signed consent form
- Copy of CTO, probation orders, etc., if applicable
- Please note all accepted clients will be required to provide a criminal background check

Please return the completed referral form and attachments to:

**Summit ACTT
871 Equestrian Court
Unit 7
Oakville, ON
L6L 6L7**

**Phone: 905-847-3206
Fax: 905-847-2959
Email: actt@summit-housing.ca
www.summit-housing.ca**