

# SUMMIT ACTT - REFERRAL FORM



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

## Demographic Data

Name:	_____	Birth Date:	_____
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:

- |  |  |
|--|--|
| <input type="checkbox"/> Inpatient voluntary | <input type="checkbox"/> Inpatient involuntary |
| <input type="checkbox"/> Outpatient          | <input type="checkbox"/> Community             |

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For an active patient/client, this consent will remain in effect until discharge from facility or at the conclusion of services.

I understand that I may withdraw this consent at any time by contacting a member of ACTT. This consent will become null & void if I become incapable of consenting to the disclosure of personal health information.

**Other community supports/services currently in use:**

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**Previous involvement with other programs:**

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**Current barriers to discharge and follow up:**

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

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

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**History of psychiatric diagnosis:**

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**Allergies:**

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**Any medical or dental issues:**

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**Current medication and treatment regime:**

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

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**Total number of psychiatric admissions:**

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**Age of illness onset:**

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**Age of first hospitalization:**

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**Most recent psychiatric admissions:**

**Service:                      Length of stay:      Admission year:      Discharge date:**

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**Describe any alcohol and/or drug use:**

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**Any history of seizures?**

yes

no

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

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**Is the client currently in an abusive situation?**

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

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

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**Describe any involvement with the law:**

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

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**Number of times incarcerated in the last two years:** \_\_\_\_\_

**Please describe how the client functions in these areas:**

**Living situation:**

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**Money management:**

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**Trustee Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Nutrition:**

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**Self care/Activities of daily living (ADL):**

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**Social/Leisure:**

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**Education:**

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**Employment:**

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**Medication management:**

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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
- Camberwell Assessment of Need – Short Appraisal Schedule (CANSAS)

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](mailto:actt@summit-housing.ca)

[www.summit-housing.ca](http://www.summit-housing.ca)

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# CANSAS

## Camberwell Assessment of Need - Short Appraisal Schedule Adapted for Summit ACTT Intake

User/Client

name: \_\_\_\_\_

Assessment date: \_\_\_\_\_

Admission date: \_\_\_\_\_

Need Rating:

0 = No problem  
1 = Met need

2 = Unmet  
3 = Not  
4 = Not  
known

Assessment number:	1	2	3	4
Who is being interviewed (U=User, S=Staff, C=Carer)?				
1. Accommodation				
2. Food				
3. Looking after the home				
4. Self-care				
5. Daytime activities				
6. Physical Health				
7. Psychotic symptoms				
8. Information on condition and treatment				
9. Psychological distress				
10. Safety to self				
11. Safety to others				
12. Alcohol				
13. Drugs				
14. Social life				
15. Intimate relationships				
16. Sexual expression				
17. Child care				
18. Education				
19. Telephone				
20. Transport				
21. Money				
22. Benefits				
<b>Met needs – Count the number of 1s in the column</b>				
<b>Unmet need – Count the number of 2s in the column</b>				
<b>Total number of needs – A + B =</b>				

\*Adaptation of CANSAS from 2005 The Royal College of Psychiatrists

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## CANSAS Information

The CANSAS is intended for routine clinical and research use. It assesses needs over the last month in 22 health and social domains. For each domain, the goal is to identify whether the service user has any difficulties, and if they do, then to establish whether they are getting sufficient help so that the difficulties are manageable. The need rating for each domain is one of:

- no need – they have no problems at all in the domain
- met need – they have no or moderate problems in the domain because of help they are given
- unmet need – a serious problem, irrespective of any help given
- not known – either not known or not disclosed

A need is met if there is currently not a serious problem, but a problem would exist if it were not for the help provided – the service user is getting effective help.

A need is unmet if there is currently a problem in the domain, whether or not any help is currently being provided.

Assessments can be recorded from the perspectives of the service user, the staff and (where applicable) the informal care giver. These perspectives often differ. For example, a smelly and oddly-dressed service user may report that they have no self-care needs. Similarly, there may be disagreement about whether the help being given is sufficient, since the difference between a met and unmet need is a matter of judgment. The goal is to differentiate between problems which are current and severe and those which are ameliorated by help, but there may still be a blurred boundary where the patient is receiving help which only partly addresses their difficulties. Therefore, it is important that the service user's views are recorded accurately, even where they differ from the staff view. The staff view is recorded separately.

For more information, please refer to:

<http://www.iop.kcl.ac.uk/virtual/?path=/hsr/prism/can/>.

February 2, 2007

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**Summit Housing & Outreach Programs  
Summit ACTT**

871 Equestrian Court, Unit 7, Oakville, ON L6L 6L7  
P: 905-847-3206 F: 905-847-2959



I, \_\_\_\_\_  
*(Print full name of person or substitute decision maker)*

of, \_\_\_\_\_  
*(Address)*

hereby authorizes (check all that apply):

X	COAST	X	Summit Housing & Outreach Programs
	Hospital:		Community Agency:
	Medical Professional:		Family:
	Halton Healthcare Services		Other:

to disclose personal health information of \_\_\_\_\_  
*(Name of client) (Date of birth)*

to \_\_\_\_\_ The Summit Assertive Community Treatment Team (ACTT) \_\_\_\_\_

of \_\_\_\_\_ 871 Equestrian Court, Unit 7, Oakville, ON L6L 6L7 \_\_\_\_\_

Specify information to be released:  verbally  copies of record or personal health information

I understand that this personal health information is to be used **only** by the recipient for the purposes of:

No information is to be released to (specify any omissions):

I hereby waive any and all claims against those named above in connection with the disclosure of this personal health information.

\_\_\_\_\_  
*(Print name of witness)*

\_\_\_\_\_  
*(Signature of client/substitute decision maker)*

\_\_\_\_\_  
*(Signature of witness)*

\_\_\_\_\_  
*(If other than client, state relationship to client)*

\_\_\_\_\_  
*Date (year/month/day)*

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