SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE

iCare

DEMOGRAPHIC LABEL

Referral - Algoma District Mental Health Programs

Please **SEND** to **ONE** of the following organizations and an intake assessment will be arranged. **Date:**

Sault Area Hospital Mental Health & Addictions Program

Select a Service:

☐ Crisis Services - Telephone 705-759-3398
Fax: 705-759-3873

☐ Eating Disorders fill out separate referral form #15382
or call 705-759-3434 ext. 4634

☐ Out Patient Mental Health Groups * call for complete Group listing*
Telephone: 705-759-3434 ext. 4600
Fax: 705-256-3453
Specify which group: CBT or DBT or _____.

☐ Transitional Care Program (Life Skills development and Ventures Program) - Telephone 705-759-3434 ext. 4634 Fax: 705-256-3469

Last Name: _____ **First Name:** _____ **Date of Birth:** _____

Preferred pronoun: _____ **Address:** _____

City: _____ **Postal Code:** _____ Health Card #: _____

Phone # (10 digits): _____ Alt # (10 digits) _____ ☐ Cell Do you text? ☐ Yes ☐ No

Permission to Leave Message: ☐ Yes ☐ No Preferred contact method: ☐ phone ☐ cell ☐ email

Email: _____ Okay to email: ☐ Yes ☐ No

Gender: ☐ Male ☐ Female ☐ Other ☐ Unknown **Highest Level of Education:** _____

Preferred Language: ☐ English ☐ French ☐ Other: _____ **Aboriginal Origin:** ☐ Yes ☐ No ☐ Unknown/Declined

Physician: _____ Psychiatrist: _____ **Psychiatric Diagnosis:** _____

Psychiatric Hospitalizations (within last 2 years):

☐ Not been hospitalized ☐ Total # of Hospitalization Days _____ ☐ Total # of Episodes _____ ☐ Unknown or Service Recipient Declined

Prescribed Psychiatric Medications: ☐ Yes ☐ No Current Legal Issues: ☐ Yes ☐ No Specify: _____

Current Situation/Comments: Please specify concerns _____

Employment: _____ **Children:** ☐ Yes ☐ No

Have you been to the emergency room due to your mental health and/or addictions during the past 30 days? Number of episodes:

Presenting Issues (check all applicable)

☐ Threat to others/attempted suicide ☐ Specific symptoms of serious mental illness ☐ Physical/Sexual Abuse ☐ Educational
☐ Occupational/Employment/Vocational ☐ Housing ☐ Financial ☐ Legal
☐ Problems with relationships ☐ Problems with substance abuse/addictions ☐ Activities of daily living ☐ Other

Is the Person aware of the Referral? ☐ Yes ☐ No **Signed Consent To Release of Personal Info on file:** ☐ Yes ☐ No
Current Involvement with other Agencies: ☐ CMHA ☐ SAH **OCAN:** ☐ Yes ☐ No

Special Considerations
Any Known Accessibility Barriers ☐ Yes ☐ No Interpretation Services Required ☐ Yes ☐ No Specify Language: _____
Any Known Safety Concerns ☐ Yes ☐ No Specify: _____

***"Special Considerations"* – Information from the referral source about safety concerns in relation to the physical environment and potential for violence will help the home visitor to complete a risk assessment. Information about accessibility and/or language barriers will help the home visitor connect with the family.**

Source of Referral: **Contact Name:** **Title**:

Organization: Phone #: Email: Fax: