SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE

iCare

DEMOGRAPHIC LABEL

SAULT AREA HOSPITAL
ASSERTIVE COMMUNITY TREATMENT TEAM(ACTT)
REFERRAL FORM

PHONE: (705) 253-9671 FAX: (705) 254-1840

Last Name: _____ First Name : _____D.O.B.: _____
Also Known As: _____ HEALTH CARD: _____
ADDRESS: _____
CITY: _____ PROVINCE: _____POSTAL CODE: _____
TELEPHONE #: (10 digits) _____ ALT. # (10 digits)_____
CURRENT PHARMACY _____PHONE_____ FAX_____

Please ensure all fields are completed and accurate. Referral forms will be returned if not completed

Gender: _____ Preferred pronouns: _____
Aboriginal Origin: ☐ Yes ☐ No ☐ Unknown/Declined ☐ Metis ☐ Status ☐ Non-status

Preferred Language: ☐ English ☐ French Other: _____
Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Common Law

Referral Date: _____
Referral Source: _____ Phone: _____EXT. _____
Current Psychiatrist: _____ Phone: _____EXT. _____
Contact Person: _____ Phone: _____EXT. _____
Current Physician: _____ Phone: _____EXT. _____

Is the client currently involved with any other Mental Health providers? ☐ Yes ☐ No
If yes, please list: _____
_____
Does the client presently have an active substitute decision maker / power of attorney?
For treatment decisions ☐ Yes ☐ No Name: _____ Phone: (____)_____
For Financial care: ☐ Yes ☐ No Name: _____ Phone: (____)_____

Documented Primary Diagnosis: _____ Secondary Diagnosis: _____
Age of onset for mental illness: _____ Age at first hospitalization: _____

Psychiatric Hospitalizations (within last 2 years)
☐ Not been hospitalized
Total # of Hospitalization Days _____ Total # of episodes _____
☐ Unknown or Service Recipient Declined

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Dates of admission to discharge, please complete the chart with discharge summaries

DATE OF ADMISSION	DATE OF DISCHARGE	DISCHARGE SUMMARY ATTACHED

**Please, note if Admission to North Bay Regional Health Centre for specialty service please provide an assessment with the admission and discharge dates.

MEDICATION HISTORY

NAME	DOSE	FREQUENCY	REASON FOR DISCONTINUING

Diagnostic Category – please check (√)one

- ☐ Adjustment Disorders
- ☐ Disorder of Childhood/Adolescence
- ☐ Dissociative Disorder
- ☐ Eating Disorder
- ☐ Sexual and Gender Identity Disorders
- ☐ Somatoform Disorders
- ☐ Schizophrenia and other Psychiatric Disorders
- ☐ Development Disorder
- ☐ Unknown or Service Recipient Declines
- ☐ Delirium, Dementia, Amnestic and Cognitive Disorder
- ☐ Anxiety
- ☐ Factitious Disorders
- ☐ Mood Disorders
- ☐ Personality Disorders
- ☐ Sleep Disorder
- ☐ Substance Use Disorders
- ☐ Impulse Control Disorders not elsewhere classified
- ☐ Mental Disorders due to General Medical condition

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Presenting Issues: Please check all that apply

- ☐ Specific Symptoms of Mental Illness
- ☐ Physical/Sexual Abuse
- ☐ Legal issues
- ☐ Problems with Substance Abuse/Addictions
- ☐ Housing
- ☐ Educational Problems
- ☐ Problems with relationships
- ☐ Occupational/Employment or Vocational Problems
- ☐ Activities of Daily Living
- ☐ Financial
- ☐ Other

Community Treatment Order: ☐ Yes ☐ No ☐ Unknown or service recipient declined

Highest Level of Education: please check (√) one

- ☐ Not in School
- ☐ Trade School
- ☐ Community College
- ☐ Unknown or Service Recipient Declined
- ☐ Elementary/Junior High School
- ☐ Vocational/Training Centre
- ☐ University
- ☐ Secondary/High School
- ☐ Adult Education
- ☐ Other

Legal Status: please select all that apply

- ☐ Pre-Charge diversion
- ☐ Awaiting trial (with or without bail)
- ☐ In-community on own recognizance
- ☐ Stay of proceedings
- ☐ Conditional discharge
- ☐ Peace bond
- ☐ ORB Detained-community access
- ☐ No legal problems (includes absolute discharge and end of sentence)
- ☐ Unknown or service recipient declined
- ☐ No criminal legal problems
- ☐ Awaiting criminal responsibility assessment (NCR)
- ☐ Unfit to stand trial
- ☐ Awaiting sentencing
- ☐ Conditional sentence
- ☐ Suspended sentence
- ☐ On parole
- ☐ Awaiting fitness assessment
- ☐ Charges Withdrawn
- ☐ NCR
- ☐ Restraining order
- ☐ ORB Conditional discharge
- ☐ On probation

Living Arrangements

- ☐ Self
- ☐ Parents
- ☐ Unknown or service recipient declined
- ☐ Spouse/Partner
- ☐ Relatives
- ☐ Spouse/Partner and others
- ☐ Non-relatives
- ☐ Children

Residence Type

- ☐ Approved homes & homes for special care
- ☐ Domiciliary Hostel
- ☐ Psychiatric Hospital
- ☐ No Fixed Address
- ☐ Municipal Non-Profit Housing
- ☐ Private House/Apt
- ☐ Retirement Home/Seniors Residence
- ☐ Supportive Housing – Congregate Living
- ☐ Other
- ☐ Correctional/Probation facility
- ☐ General Hospital
- ☐ Other specialty Hospital
- ☐ Long Term Care Facility/Nursing Home
- ☐ Private Non-Profit Housing
- ☐ Private House/Apt/Other – Subsidized
- ☐ Rooming/Boarding
- ☐ Supportive Housing – Assisted Living
- ☐ Unknown or Service Recipient Declined

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Residence Status

- ☐ Independent
- ☐ Assisted/Supported
- ☐ Supervised Non-Facility
- ☐ Supervised Facility
- ☐ Unknown or Service Recipient
- ☐ Declined

Employment

- ☐ Independent/Competitive
- ☐ Assisted/Supported
- ☐ Alternative Business
- ☐ Sheltered Workshops
- ☐ No employment of any kind
- ☐ Casual/sporadic
- ☐ No Employment – other activity
- ☐ Non-Paid Work Experience casual/sporadic
- ☐ Unknown or service recipient declined

Primary Income

- ☐ Employment
- ☐ Employment Insurance
- ☐ Pension
- ☐ ODSP
- ☐ Social Assistance
- ☐ Disability Assistance
- ☐ Family
- ☐ No source of income
- ☐ Other
- ☐ Unknown or Service Recipient Declined

I have reviewed the PACT Program with the client:	☐ Yes	☐ No
The client consents to the PACT referral:	☐ Yes	☐ No
Any known safety concerns:	☐ Yes	☐ No

Specify: _____

_____ _____
Referral Source's Signature Date

I _____, hereby agree and consent to SAH sharing information about my emergency department admissions or any other inpatient admission with staff in the SAH PACT Program to determine suitability for PACT services.

If additional information is required by SAH PACT to determine program eligibility, the SAH PACT program may access additional personal health information regarding SAH medical records.

_____ _____
Client Signature Date

If client is not capable to consent, the consent must be signed by the Substitute Decision Maker.

_____ _____
Substitute decision maker (print & sign) Date