



Alexandra Marine & General Hospital

Mental Health Outpatient Referral Form

Clinical Intensive Case Management and Huron Community Mental Health Services

Our service is unable to provide support in an emergency. If your client is experiencing a mental health crisis and requires immediate help, advise them to contact the Huron Perth Helpline and Crisis Response Team at 1-888-829-7484, or go to the nearest emergency department.

Important Information:

- This referral is NOT for psychiatry. To refer to a psychiatrist, please contact the department of psychiatry with Alexandra Marine & General Hospital at 519-524-8323 ext. 5361 or 5388.
- All sections of this form must be complete in order to proceed with the referral and the individual being referred must be aware that a referral is being made to Outpatient Mental Health Services.
- Referrals can be faxed to 519-524-9349. Incomplete referrals will be sent back to the referent.

Program referring to:

HCMHS: Huron Community Mental Health Services welcomes individuals from Huron County, 16 years of age and over seeking treatment for their mental health. Individual and group treatment services are offered in our Goderich, Wingham, Clinton, Exeter and Seaforth offices.

CICM: Clinical Intensive Case Management services provide time limited, goal-specific in-home community treatment in Huron & Perth Counties. The program focusses on relapse prevention & stabilization in the community utilizing psychological education, medication management, liaising with partner agencies & advocacy.

<p>Referral Checklist - HCMHS:</p> <ul style="list-style-type: none"> <input type="checkbox"/> 16 years of age or older <input type="checkbox"/> Ready/willing to engage in goal-oriented therapy <input type="checkbox"/> Aware clients may be asked to engage in group treatment <input type="checkbox"/> Experiencing moderate to severe mental health challenges <input type="checkbox"/> Resident of Huron County <input type="checkbox"/> Able to attend regular appointments <input type="checkbox"/> Aware clients may be asked to explore/access mental health supports through EAP, private benefits, and/or Family Health Team 	<p>Referral Checklist – CICM:</p> <ul style="list-style-type: none"> <input type="checkbox"/> 16 years of age or older <input type="checkbox"/> Ready/willing to engage in time-limited goal specific treatment <input type="checkbox"/> Experiencing serious mental health challenges <input type="checkbox"/> Resident of Huron or Perth Counties
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Demographic Information

Legal Name: _____ Gender: _____ Pronouns: _____

Preferred Name: _____ Birth Date: _____

Date: _____ Health Card #: _____ Version: _____

Contact Information

Contact Number: _____ Consent to leave detailed voicemail

Mailing address: _____ Consent to contact by mail

Email address: _____ Consent to provide appt reminder by email

Emergency contact: _____ Consent to contact

Relationship and Phone Number: _____

Reason for Referral

Please describe the reasons for the referral including presenting concerns, frequency and duration of symptoms, psychosocial factors and what lifestyle, behavioural, cognitive or emotional changes they would like to make regarding their mental health. Please indicate self-identified goals of care. Attach if details cannot fit in space provided:

Referral Source

Name: _____ Organization: _____

Telephone: _____ Fax: _____ Will you continue to provide care?: _____

Supports

Psychiatrist: _____

Telephone: _____ Fax: _____

Primary Care Provider: _____

Clinic: _____ Telephone: _____ Fax: _____

Other Provider: _____

Clinic: _____ Telephone: _____ Fax: _____

Other formal or informal supports: _____

Mental Health

Psychiatric Diagnosis, if known: _____

Past suicide attempts/self-harming: _____

Hospital Presentations

For mental health related reasons, please provide dates and details:

Medical History

Describe any relevant medical issues that impact mental health:

Please list any allergies: _____

Barriers to Treatment

Describe any vision, hearing, mobility, transportation, or stigma related barriers to treatment:

For CICM Specific Referrals

Are there any environmental concerns to be aware of in the home (e.g. pets/animals; smoking, others residing in the home, etc.)? *Please note we ask that clients do not smoke/vape during appointments*

Substance Use

Do drugs or alcohol interfere with your ability to engage in the following?

ADL's: Social Life: Work: Home Life:

Details (e.g. indicate substance used, medication misuse, treatments engaged in, history and last use):

Protective Factors

List any known protective factors (i.e. steady employment, stable housing, supportive relationships, engagement in services, involvement in prosocial recreational activities):

Previous Law Enforcement/Legal Involvement and Safety

Current Charges: Yes No Unknown Details: _____

Past Charges: Yes No Unknown Details: _____

No Contact Orders: Yes No Unknown Details: _____

On Probation or Parole: Yes No Unknown Details: _____

Past Charges Dismissed/Diversion Completed: Yes No Unknown Details: _____

Any episodes of harm towards others? Yes No Unknown Details: _____

Any episodes of property damage? Yes No Unknown Details: _____

Are there any additional safety risks staff should be aware of in delivering services? Yes No Unknown

Details:

Are there any specific details that we should be aware of to help us create a safe space for this person?