# Assertive Community Treatment Team
# Central Intake
## COMMUNITY MENTAL HEALTH PROGRAM

The Assertive Community Treatment Team (ACTT) helps people with complex, long-term and serious psychiatric illness involving multiple hospitalizations of a minimum of 50 days in past year or 150 days over 3 years. An individual, the family or the current service provider can make referrals. A central intake team reviews referrals for all Ottawa area ACTT. A client assessment will be done to determine eligibility for ACTT services.

### Services include:

- Identify and achieve individual goals *(such as life skills, vocational, education, financial, recreation, etc)*
- After hours emergency services for clients in the service
- Symptom assessment, management and education
- Supportive counselling
- Medication education, prescription administration and monitoring

### Please send to:

*For ACT teams*

c/o Intake Coordinator

1145 Carling Avenue

Ottawa ON K1Z 7K4

Tel: 613.722.6521 ext. 7325

Fax: 613.739.8400

**PLEASE NOTE THAT ALL**
**INCOMPLETE REFERRAL FORMS WILL BE RETURNED TO SENDER**

Centre de santé communautaire Pinecrest-Queensway Community Health Centre

Hôpital Montfort

Carlington Community Health Centre

The Le Royal
Mental Health - Care & Research
Santé mentale - Soins et recherche

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## CLIENT CONSENT

For Long-Term Community Mental Health Support Referrals

The Assertive Community Treatment (ACT) Teams and the Intensive Case Management Services work in collaboration with each other. To make the process easier for you, we request your permission to discuss your referral at our joint monthly meetings and with other service providers involved in your care.

*Please sign below giving your consent.*

Date: _____

Client name: _____
(Please print)

Client signature: _____

_____
(If other than the patient, state relationship to the patient. Please sign and print name.)

Witness name: _____
(Please print)

Witness signature: _____

**MHCSS – Partner in Case Management**

Canadian Hearing Society
Horizons Renaissance Inc.
Ottawa Salus Corporation
Project Upstream
Somerset West Community Health Centre
Canadian Mental Health Association, Ottawa
Ottawa Carleton Immigrant Services
Pinecrest Queensway Health & Community Services
Royal Ottawa Health Care Group

Centre de santé communautaire Pinecrest-Queensway Community Health Centre
Hôpital Montfort
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Date of referral: _DD_ /_MM_ /_YY_

## SECTION 1: Client information

Last name:_____ First name:_____ Marital status: _____

Date of birth: _DD_ /_MM_ /_YY_ Sex : ❑ F ❑ M

Address:

Telephone: ____/____/____ Source of income: _____

Aboriginal: ❑ Yes ❑ No

Language: ❑ English ❑ French ❑ Other: _____

Health card # : _____

Emergency contact: _____

Highest level of education: _____

## SECTION 2: Source of referral

Primary referral source:

Agency:_____

Address:

Telephone: ____/____/____ Fax: ____/____/____

E-mail address:_____

## SECTION 3: Reason for referral

Explain briefly:

**PSYCHIATRIC DIAGNOSIS AND HEALTH:**

Diagnosis: PRIMARY:_____ SECONDARY: _____

Physical problems: _____

Age of onset of illness: _____

**CURRENT MEDICATIONS:** *please use separate sheet*

**HOSPITALIZATIONS:** *please include dates, duration and institution. Please add separate sheet, if required.*

Age of first hospitalization: _____

| DATE | DURATION | INSTITUTION |
|---|---|---|
| | | |
| | | |
| | | |

**HOMELESSNESS:** *please include dates over the past two years*

**SUBSTANCE ABUSE:**

Does the client struggle with substance abuse? ❑ Yes ❑ No

If yes, specify:

| FUNCTIONAL ABILITIES: | Yes | No |
|---|---|---|
| Meets basic needs *(housing, food)* | ❍ | ❍ |
| Carries out activities of daily living required for basic functioning in the community *(ex. : getting to and from places, medical care, personal hygiene)* | ❍ | ❍ |
| Maintains safe housing *(no eviction nor loss of housing)* | ❍ | ❍ |
| Maintains vocational activity *(school, volunteering, or employment)* | ❍ | ❍ |
| Family and/or social network involvement | ❍ | ❍ |
| History of suicide attempts | ❍ | ❍ |
| History of harm to others | ❍ | ❍ |
| Has person been declared financially incompetent? | ❍ | ❍ |
| Does he/she have a Public Guardian and Trustee? | ❍ | ❍ |
| Has person been declared incompetent to make treatment decisions? | ❍ | ❍ |
| Substitute decision maker *(name, relationship and telephone)?* | ❍ | ❍ |

Name _____ Relationship _____ Telephone _____

**LEGAL:**

Dates and duration of incarcerations over past 2 years:

Reasons/charges: _____

Court Order: _____

Is person under a Community Treatment Order? ❑ Yes ❑ No

Date of issuance: DD / MM / YY Issuing physician: _____

Has person been declared Not Criminally Responsible? ❑ Yes ❑ No

**OTHER SERVICES:**

| NAME | ADDRESS | TELEPHONE |
|---|---|---|
| | | |
| | | |
| | | |

**Has this referral and potential assessment been discussed with:**

Client ❑ Yes ❑ No

Family ❑ Yes ❑ No

Other *(specify):* _____

**PLEASE ENSURE THAT ALL PERTINENT INFORMATION IS INCLUDED WITH REFERRAL. PLEASE CHECK BOXES.**

❑ consent to disclose health information signed by client

❑ admission/discharge summaries of past psychiatric hospitalizations over the past 2 years

❑ consultation reports or other significant documents within past 2 years

❑ case and or social histories

## VIOLENCE / AGGRESSION ASSESSMENT CHECK LIST (VACC)

**Known history of violence** ❑ Yes ❑ No

### BEHAVIOUR AND RISK

Please indicate if the patient has recently exhibited any of the following type of behaviour below:

❑ Uncooperative ❑ Verbal abuse ❑ Hostile/attacking objects

❑ Threats ❑ Assaultive/combative ❑ No aggressive behaviour exhibited

**Known risk factors/triggers** *(enter 'none' if there are no known risk factors/triggers or if this question is not applicable)*

**Mitigation strategies for Known risk factors/triggers** *(enter 'none' if there are no known mitigation strategies or if this question is not applicable)*

**Level of risk** ❑ low ❑ moderate ❑ high

**Current risk mitigation strategies/intervention** *(enter 'none' if there are no risk mitigation strategies/intervention)*