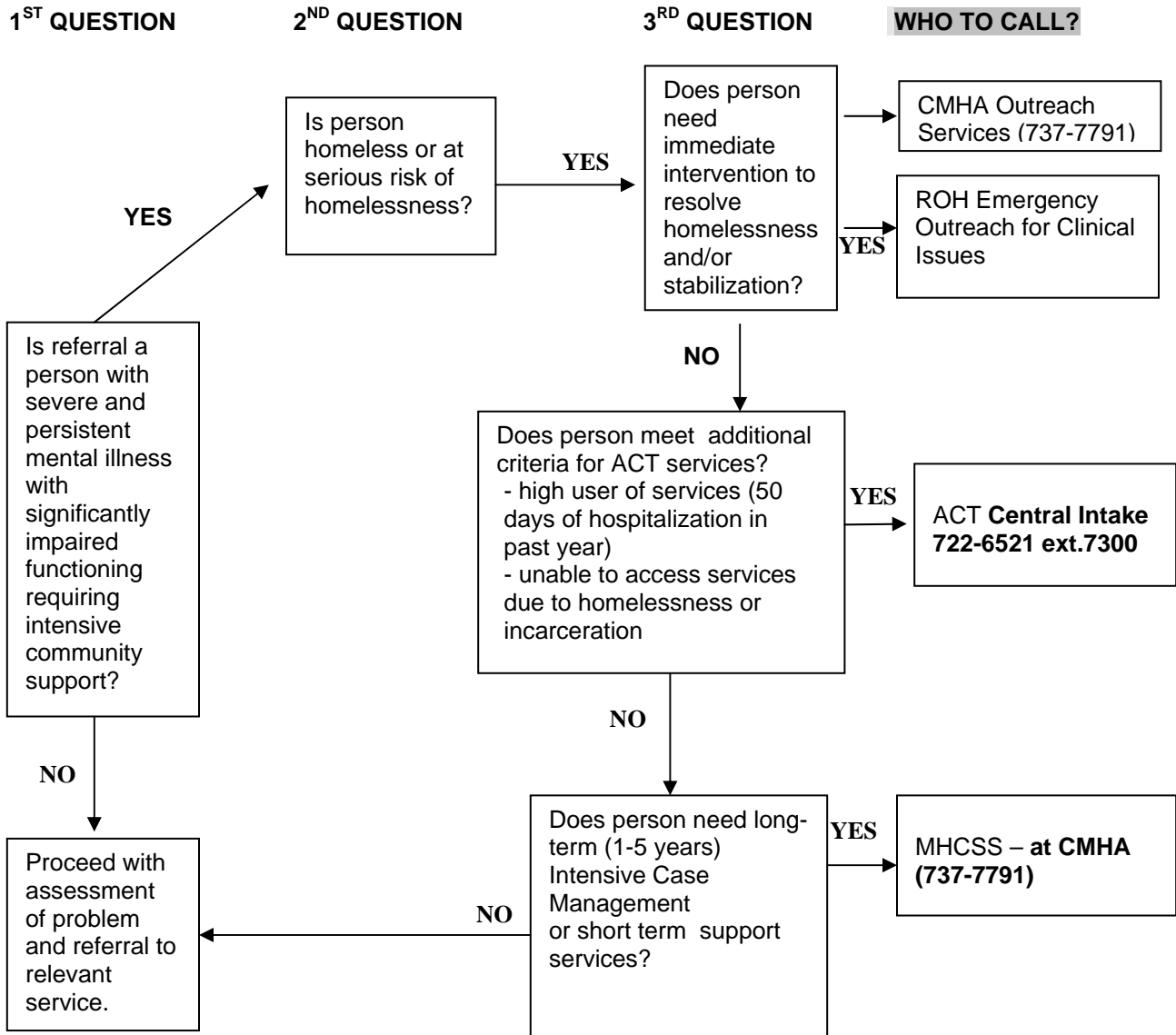


DECISION TREE FOR REFERRALS TO LONG-TERM COMMUNITY MENTAL HEALTH SUPPORT

- ❑ There are a range of services provided in Ottawa: outreach, intensive case management and ACT (Assertive Community Treatment).
- ❑ The following questions are intended as a guide for referrals.



PROGRAM ELIGIBILITY CRITERIA

A. ESSENTIAL CRITERIA

Individual:

1. Appears to have a severe and persistent mental illness.
2. Is a resident of Ottawa.
3. Is 16 years of age or over. (Youth may have special agreements with CAS.)
4. Has had frequent breakdowns in community living (e.g., has been hospitalized).
5. Has or may suffer a breakdown in community living because of functional limitations.
6. Has one of the following **Service Needs**:
 - Requires assistance to use resources appropriately. Client may be overusing or under using services so that needs are not being met.)
 - Requires help to access services.
 - Advocacy to change service criteria in order to serve the individual, or to develop a new resource for the client.
 - Assistance/support to accept needed services.
7. Has one or more of the following **Support Needs**:
 - Is isolated without social or family support.
 - Lacks professional support.
 - Family support is problematic, in jeopardy, or absent.
 - Functional impairment in more than one skill area: daily living , social, educational, vocational.

Ministry of Health Definition

- **Diagnosis** such as schizophrenia, major affective disorders, personality disorders, paranoid and other psychoses should be present **or** person demonstrates a pattern of behaviours that indicate a severe a persistent mental illness.
- **Disability** refers to the fact that the disorder interferes with the person's capacity to organize and complete the activities of daily living.
- **Duration** may be based on a **severe** first episode or a chronic nature of the illness,

B. DESIRABLE (These indicators are not essential but reinforce the need for case management.)

- Acknowledgement by client of need for support within a six month period of engagement.
- Acknowledgement by client of need to develop or maintain a network.
- Need for a service is urgent at time client is being considered.
- Is homeless or at risk of becoming homeless
- Has other complex needs.

C. ADDITIONAL CRITERIA (These indicators may also reinforce the need for support services.)

- Loss of major supports (e.g., family) anticipated.
- Service is needed to maintain recent rehabilitation gains (i.e., from supportive housing or hospital services).
- Individual has multiple problems which require coordination, bridging across and between service systems.
- Presence of concurrent disorder
- Presence of a dual diagnosis

Check only one please:

- o Ottawa Assertive Community Treatment Teams
OR
- o Mental Health Community Support Services

REFERRAL FORM

Date of referral (D/M/Y) : _____

SECTION I: Client information

1) Demographic data

Last name : _____ First name : _____ Marital Status : _____

Date of birth (D/M/Y) : _____ Sex : F M

Address : _____

Telephone : (____) _____ Source of income : _____

Language preference : English French Other : _____

Health card # : _____ Social Insurance # : _____

Emergency contact : _____

SECTION II: Source of referral

Primary referral source : _____

Agency : _____

Address : _____

Telephone : (____) _____ Fax : (____) _____

SECTION III: Reason for referral

Explain briefly :

REFERRAL FORM

2) Psychiatric diagnosis and health

Diagnosis : PRIMARY : _____ SECONDARY : _____

Physical problems : _____

Current medications :

NAME	DOSAGE / FREQUENCY

(Continue on extra sheet if needed)

3) Hospitalizations (over past 2 years)

DATE	DURATION	INSTITUTION

(Continue on extra sheet if needed)

4) Homelessness

Dates and duration of homelessness over past 2 years : _____

5) Substance abuse

Does the client struggle with substance abuse? Yes No

If yes, specify _____

6) Functional abilities

	Yes	No
Meets basic needs (housing, food).....	<input type="radio"/>	<input type="radio"/>
Carries out activities of daily living required for basic functioning in the community (ex.: getting to and from places, medical care, personal hygiene).....	<input type="radio"/>	<input type="radio"/>
Maintains safe housing (no eviction or loss of housing).....	<input type="radio"/>	<input type="radio"/>
Maintains vocational activity (school, volunteering, or employment).....	<input type="radio"/>	<input type="radio"/>
Family and/or social network involvement.....	<input type="radio"/>	<input type="radio"/>
History of suicide attempts.....	<input type="radio"/>	<input type="radio"/>
History of harm to others.....	<input type="radio"/>	<input type="radio"/>
Has person been declared financially incompetent.....	<input type="radio"/>	<input type="radio"/>
Does he/she have a Public Guardian and Trustee.....	<input type="radio"/>	<input type="radio"/>
Has person been declared incompetent to make treatment decisions.....	<input type="radio"/>	<input type="radio"/>
Substitute decision maker (name and relationship).....	<input type="radio"/>	<input type="radio"/>

REFERRAL FORM

7) Legal

Dates and duration of incarcerations over past 2 years : _____

Reasons/charges : _____

Other legal problems over past 2 years : _____

Is person under a Community Treatment Order? Yes No

Date of issuance : _____ Issuing physician : _____

Has person been declared Not Criminally Responsible? Yes No

8) Other services involved with client :

NAME	ADDRESS	PHONE NUMBER

***Please ensure Consent to Disclose Personal Health Information for above services are enclosed permitting two-way communication.**

Has this referral and potential assessment been discussed with :

Client	Yes	No
Family	Yes	No
Other (specify) :	_____	

Please include Consent to Disclose Personal Health Information signed by client releasing information to ACT Central Intake & MHCSS from referral source and hospitals involved in the past.

*** Please attach information requested below :

- 1) Discharge summaries of past psychiatric hospitalizations over past 2 years
- 2) Consultation reports or other significant documents within past 2 years
- 3) Consent to Disclose Personal Health Information form

N.B. Please note that all incomplete forms will NOT BE PROCESSED.

S.V.P. Please forward the completed form to the following address :

For intensive case management (MHCSS)

c/o Canadian Mental
Health Association
1355 Bank Street, 3rd floor
Ottawa, Ontario K1H 8K7
Telephone : (613) 737-7791
Fax : (613) 737-7644

For ACT teams

Royal Ottawa Hospital Health Care Group
Intensive Assessment and Intervention Program
Bank Street ACT Team
Att: Intake Coordinator
205-1355 Bank Street
Ottawa, ON K1H 8K7
Telephone (613) 737-7791
Fax: (613) 739-8400

If you do not meet criteria for these programs, you will be given suggestions for other mental health resources.



Consent To Disclose Personal Health Information

I, _____, hereby authorize

 (Name of person or agency)

to disclose to the *Canadian Mental Health Association Ottawa Branch* relevant personal

information /personal health information in respect of _____,
 (Name of Person)

 (Date of Birth)

I also consent to the collection of this information by the *Canadian Mental Health Association Ottawa Branch* for the purpose of providing mental health services.

I, _____, hereby authorize the *Canadian Mental Health Association Ottawa Branch* to disclose relevant personal health information in respect of

_____, _____ to
 (Name of Person) (Date of Birth)

 (Name of person or agency)

My consent to this disclosure(s) expires in one year if I do not indicate otherwise.

(My consent to this disclosure(s) expires _____/_____/_____)
 (Day) (Month) (Year)

I am aware that I can refuse to sign this consent form.

I am aware that I can cancel or amend this consent at any time in writing.

Signature: _____ Date: _____

(If signed by a Substitute Decision Maker, please specify the relationship: _____)

Witness: _____