South Eastern Ontario Addictions & Mental Health Service Access Form

Please check <u>one</u> of the following:

AMHS-HPE + QHC Outpatient Counselling	Kingston Outpatient MH Services	AMHS-KFLA	LANARK COUNTY	LLGAMH	REGIONAL TERTIARY SERVICES
☐ **Open Line Open Mind** Tel: 310-OPEN Fax: 613-961-2528	☐ **KGH ITTP Day Hospital** **Tel:** 613-549-6666 ext 7622 Fax: 613-548-6032 ☐ **Hotel Dieu Hospital, MH Services** Tel:613-544-3400 x2551 Fax: 613-548-6095	☐ **Kingston & Frontenac** Tel: 613-544-1356 Fax 613-544-2346 ☐ Lennox & Addington Tel: 613-354-7521 Fax: 613-354-7524	☐ **Lanark County Mental Health** Tel: 613-283-2170 Fax 613-283-9018	☐ **Central Intake** Tel: 613-342-2262 1- 866-499-8445 Fax: 613-342-4969	☐ **Providence Care, Mental Health Services** Tel: 613-546-1101 Fax: Please see below

REFERRAL SOURCE

Agency / Source: Telephone:

Fax:

Date of Referral (yyyy/mm/dd): / / Physician Billing #:

Identification of first language:
☐ English ☐ French ☐ Other: _____

☐ **Check here to indicate that we can contact the most appropriate service for your client and redirect the referral**

☐ **Check here to indicate that information can be shared with GP**

CLIENT INFORMATION

Name:

Address:

City: Postal Code:

Preferred Contact #: Alternate Contact #:

Can message be left at this number? ☐ Yes ☐ No

Substitute Decision Maker: Contact #:

Date of Birth (yyyy/mm/dd): / /

Family Physician / Psychiatrist: (if different from referrer)

Telephone (direct):

Address:

☐ ***Psychiatric Consultation** ***(*Physician referral & OHIP Req'd)***
PHYSICIAN SIGNATURE:
(Required for psychiatry) _____

COMMUNITY SERVICES – Service Requested
☐ Community Addictions or Mental Health Support Services
☐ Housing
☐ Assertive Community Treatment Team (ACTT)
☐ Other (please specify):

***Health Card #:** ***V-code:** ***Exp. Date:**

PROVIDENCE CARE (Tertiary Services) – Service Requested
☐ Personality Disorder Service (Fax: 613-542-1400)
☐ Mood Disorder Specialty Outpatient (Fax: 613-540-6114)
☐ ACTT & Case Management (Fax: 613-540-6114)
☐ Community Treatment Order Program (Fax: 613-540-6139)
☐ Dual Diagnosis Consultation Outreach Team (Fax: 613-530-2212)

Comments *(please attach any relevant information regarding psychiatric diagnosis, medical conditions, medications, etc.)*:

RISK FACTORS				CURRENT SITUATION / HISTORY / DIAGNOSIS			
	Yes	**No**	**Comments**		**Yes**	**No**	**Comments**
Harm To Self				Psychiatric Diagnosis			
Harm To Others				Medications: (attach list)			
Inability To Care For Self							
Financially Incapable				Medical Conditions:			
Other Risk Factors *i.e. Pregnancy, Gambling, Concurrent disorders*				Past / present involvement with MHA or other agencies			
Current Legal Issues							

CONSENT

Consent for Service Verbal ☐ Signed ☐ *Note: Please append signed consent forms*
Consent for Disclosure Verbal ☐ Signed ☐

Referral Taken By: (print name) _____

Referral Taken By: (signature) _____ **Date** (yyyy/mm/dd)**:** _____