Service Request Form

please ***COMPLETE FORM*** *and fax to* ***ONE*** *of the referring agencies*

1)	***Hamilton Assertive Community Treatment Teams (ACTT)***	***tel: 905-528-5354***	***fax: 905-528-8442***
2)	***Intensive Case Management Access Coordination (IntAc)*** ***NOTE: Please call IntAc directly for Street Outreach referrals***	***tel: 905-528-0683***	***fax: 905-546-0055***
3)	***Schizophrenia Outpatient Clinic (SOC)***	***tel: 905-522-1155 x 39044***	***fax: 905-527-7301***

Service Request Type:
PLEASE CHECK ONE

☐ 1. ACTT ***include admission/discharge summaries & social work history from last hospital admission***

☐ 2. IntAc
- ☐ Street Outreach (client is homeless) ** = must complete
- ☐ Intensive Case Management

☐ 3. SOC
- ☐ Diagnostic Consult
- ☐ Medication Consult
- ☐ Psychiatric Follow-up

Clinician:** Date of Referral:**

Client Information

Name:**	DOB: (YYYY MM DD)	Age:	Gender:**	Marital Status:	☐ Aboriginal ☐ Non-Aboriginal

Health Card #:	VC:	Does client have a physical disability?** *If yes, explain:*	☐ Yes	☐ No
Address / Emergency Shelter / Last Location Seen:**		Physical Description of Client:** *for Street Outreach Only*		
		Can client speak/understand English?**	☐ Yes	☐ No
Phone #:** *if available*		Is there a Community Treatment Order (CTO)?	☐ Yes	☐ No
Emergency Contact Information:** *if available*		ORB involvement?	☐ Yes	☐ No
		Is the client in the HOMES Program?	☐ Yes	☐ No

Referral Source

Self Referral?** ☐ Yes ☐ No *If no* Is client aware of referral?** ☐ Yes ☐ No

Name: **		Position Title:
Agency Name:** *if applicable*		
Phone:** *if applicable*	Ext.:	Fax:

Referral Source (role, frequency, length of time involved and client's response):** *if applicable*

Do staff need to be aware of any past or current safety or behavioural issues when approaching the client?** *If yes, explain:* ☐ Yes ☐ No

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Referral Source *cont'd*

Diagnosis:
Axis I:

Axis 2:

Axis 3:

Has the client been referred within the past 6 months? ☐ Yes ☐ No *If yes* to which agency:

Are you referring the client to other agencies? *If yes* please explain:

Rationale for level of service ı

Has the client provided verbal permission to contact his/her clinician? ☐ Yes ☐ No ☐ N/A

Specialists or Other Agencies Involved *(include past mental health services)*

Indicate involvement with any of the following:	Comments:
☐ counselling services ☐ vocational services ☐ probation / parole ☐ addiction services ☐ Children's Aid Society ☐ housing program ☐ other *(specify)*	

Family Physician				**Psychiatrist**			
Name:	Phone:			Name:	Phone:		
Office Address:				Office Address:			
Is family physician aware of referral?	☐ Yes	☐ No		Is psychiatrist aware of referral?	☐ Yes	☐ No	
Is he/she willing to work with ACTT/IntAc/SOC?	☐ Yes	☐ No		Is he/she willing to work with ACTT/IntAc/SOC?	☐ Yes	☐ No	

Current Supports / Contacts *(professional and family)*

Name:	Relationship:	Phone:

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Current and Past Legal History

Is the client currently on probation/parole? ☐ Yes ☐ No *If yes* followed by:

Was client previously on probation/parole? ☐ Yes ☐ No *If yes* followed by:

Current and Past Psychiatric History *(please check and make comments where relevant)*

☐ SUICIDE HISTORY

☐ AGGRESSIVE BEHAVIOUR

☐ SUBSTANCE ABUSE

☐ HOSPITALIZATIONS

☐ COMMUNITY TREATMENT ORDER

***Please indicate all those that apply*:**

- ☐ finances
- ☐ housing, household management, evictions
- ☐ family relationships
- ☐ interpersonal skills
- ☐ personal care
- ☐ medication compliance
- ☐ follow-up compliance
- ☐ school/vocational activities
- ☐ social/leisure activities
- ☐ literacy
- ☐ language
- ☐ other ***(specify)***

EMPLOYMENT current status:

EDUCATION highest level:

***Please indicate all those that apply*:**

- ☐ violence toward self
- ☐ violence toward others
- ☐ violence toward property
- ☐ sexual assault
- ☐ head injury
- ☐ developmental delay ***(neuropsychological testing is required)***
- ☐ fire setting
- ☐ other ***(specify)***

***Please indicate all those that apply*:**

- ☐ high risk or recent history of criminal justice involvement
- ☐ would require institutional placement without intensive support
- ☐ severe or intractable major symptoms
- ☐ otherwise unable to participate in office-based services
- ☐ 60 or more days in hospital **OR** five or more ER visits **OR** three or more hospitalizations in last year
- ☐ coexisting substance abuse disorder

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Current and Past Medical History

Current Medications *(please attach list)*

Document Allergies

Rehabilitation Goals

Goals identified by client:

Comments

Please provide any other relevant information as needed:

Please complete for referrals to SOC only:

Referring Physician name (please print)

Referring Physician Signature

Billing #