

South Eastern Ontario Addictions & Mental Health Service Access Form

Please check one of the following:

<p>AMHS-HPE + QHC Outpatient Counselling</p> <p>Open Line Open Mind <input type="checkbox"/> Tel: 310-OPEN Fax: 613-961-2528</p>	<p>Kingston Outpatient MH Services</p> <p><input type="checkbox"/> KGH ITTP Day Hospital Tel: 613-549-6666 ext 7622 Fax: 613-548-6032</p> <p><input type="checkbox"/> Hotel Dieu Hospital, MH Services Tel: 613-544-3400 x2551 Fax: 613-548-6095</p>	<p>AMHS-KFLA</p> <p><input type="checkbox"/> Kingston & Frontenac Tel: 613-544-1356 Fax: 613-544-2346</p> <p><input type="checkbox"/> Lennox & Addington Tel: 613-354-7521 Fax: 613-354-7524</p>	<p>LANARK COUNTY</p> <p><input type="checkbox"/> Lanark County Mental Health Tel: 613-283-2170 Fax: 613-283-9018</p>	<p>LLG-AMHS</p> <p><input type="checkbox"/> Central Intake Tel: 613-342-2262 1- 866-499-8445 Fax: 613 342 4969</p>	<p>REGIONAL TERTIARY SERVICES</p> <p><input type="checkbox"/> Providence Care, Mental Health Services Tel: 613-544-4900 Fax: Please see below</p>
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REFERRAL SOURCE

Agency / Source:	Telephone:
	Fax:
Date of Referral (yyyy/mm/dd): / /	Physician Billing #:

Identification of first language: <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other: _____	<input type="checkbox"/> Check here to indicate that we can contact the most appropriate service for your client and redirect the referral <input type="checkbox"/> Check here to indicate that information can be shared with GP
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CLIENT INFORMATION

Name: Address: City: Postal Code: Preferred Contact #: Alternate Contact #: Can message be left at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No Substitute Decision Maker: Contact #: Date of Birth (yyyy/mm/dd): / /	Family Physician / Psychiatrist: (if different from referrer) Telephone (direct): Address: Health Card #: V-code: Exp. Date (yy/mm): /
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<p>COMMUNITY SERVICES – Service Requested</p> <p><input type="checkbox"/> Community Addictions or Mental Health Support Services <input type="checkbox"/> Psychiatric Consultation (<i>Physician referral only</i>) <input type="checkbox"/> Housing <input type="checkbox"/> Assertive Community Treatment Team (ACTT) <input type="checkbox"/> Other (please specify):</p>	<p>PROVIDENCE CARE (Tertiary Services) – Service Requested</p> <p><input type="checkbox"/> Personality Disorder Service (Fax: 613-542-1400) <input type="checkbox"/> Mood Disorder Specialty Outpatient (Fax: 613-540-6114) <input type="checkbox"/> ACTT & Case Management (Fax: 613-540-6114) <input type="checkbox"/> Community Treatment Order Program (Fax: 613-540-6139) <input type="checkbox"/> Dual Diagnosis Consultation Outreach Team (Fax: 613-530-2212)</p>
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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>i.e. Pregnancy, Gambling, Concurrent disorders</i>				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): _____