

South Eastern Ontario Addictions & Mental Health Service Access Form

Please check one of the following:

HASTINGS & PRINCE EDWARD COUNTIES <input type="checkbox"/> Open Line Open Mind Tel: 310-OPEN Fax: 613-961-2528	LENNOX & ADDINGTON <input type="checkbox"/> L&A Addiction and Community Mental Health Services Tel: 613-354-7521 Fax: 613-354-7524	KINGSTON & FRONTENAC <input type="checkbox"/> Frontenac Community MH&A Services Tel: 613-544-1356 Fax 613-544-2346 <input type="checkbox"/> Hotel Dieu Hospital, Mental Health Services Tel: 613-544-3440x2551 Fax: 613-548-6095	LANARK COUNTY <input type="checkbox"/> Lanark County Mental Health Tel: 613-283-2170 Fax 613-283-9018 <input type="checkbox"/> TriCounty Addiction Services Tel: 613-283-7723 Fax: 613-283-9407	LEEDS & GRENVILLE <input type="checkbox"/> Central Intake Tel: 613-342-2262 866-499-8445 Fax: 613 342 4969 <input type="checkbox"/> TriCounty Addiction Services Tel: 613-345-7453 Fax: 613-345-7761	REGIONAL TERTIARY SERVICES <input type="checkbox"/> Providence Care, Mental Health Services Tel: 613-546-1101 Fax: Please see below
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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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COMMUNITY SERVICES – Service Requested <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):	PROVIDENCE CARE (Tertiary Services) – Service Requested <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: 613-540-2212)
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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 <input type="checkbox"/>	Signed <input type="checkbox"/>	<i>Note: Please append signed consent forms</i>
Consent for Disclosure	Verbal <input type="checkbox"/>	Signed <input type="checkbox"/>	

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