St. Joseph's Healthcare Hamilton

Central Rehabilitation Resource Clinic
Schizophrenia and Community Integration Service
Mental Health and Addiction Program
West 5th Campus-Office G230
100 West 5th Street, PO Box 585
Hamilton, ON L8N 3K7
Phone: 905.522.1155 ext. 39559 Fax: 905.381.5654

Schizophrenia & Community Integration Service – Centralized Rehabilitation Resource Clinic (CRRC)- West 5th Campus is pleased to provide a number of services for individuals who experience a serious mental illness.

Anyone may make a referral including: psychiatrist, family doctor, community worker, family members or self-referral. To ensure your referral is received and processed in the quickest manner please read the following procedures. If the information on the referral is not completed accurately, there will be delays in anticipated program start dates.
Note: We are not a case management service and clients being referred to CRRC require follow up care.

While we have adapted the common CONNECT referral form, all referrals for CRRC should be directly faxed to 905-381-5654 or mailed to the address above.

How to complete the referral form:

- Please clearly indicate in the **Presenting Concerns /Referral Goal** section of the Connect referral form, that the referral is for CRRC;
    - 1:1 Therapeutic Recreation
    - Transition Fitness
    - Yoga
    - Smart Start
    - Photovoice
    - Stretch and Strengthen

- Add any additional concerns related to your referral.
- Complete the PARQ form
- Complete the Authorization for Disclosure form to Family Physician
- Return all completed forms by fax or mail to the number and address above

All referrals will be processed within 2 weeks. Clients who are concerned about the status of their referral are welcome to call us for an update

Brief program descriptions

Therapeutic Recreation: Therapeutic Recreation service utilizes functional intervention, leisure education and recreation participation processes. Service is focused on the acquisition and maintenance of resources, skills, knowledge and behaviours, which allow for independent functioning and optimal benefits of a balanced leisure lifestyle. A referral to Therapeutic Recreation can provide services within physical, social, cognitive, spiritual and affective domains, on site and in the community. 1:1 service includes assessment, goal setting, support with implementation and evaluation of progress. Central Rehabilitation Resource Clinic also coordinates West 5th Campus recreation therapy participation programs and events 7 days a week, on weekends and evenings, which do not require a referral and are advertised through our monthly calendar. Referrals for specific group programs may include Yoga, Smart Start, Fitness Programs and Leisure Education Groups.

Current CRRC Therapeutic Recreation Referral Based Offerings in addition to 1:1 Service

Transition Fitness: The goals of the program include gaining knowledge, building skill and practicing safe and effective physical fitness techniques. Orientation to the W5th fitness facility with education for safe use of equipment, development of a fitness program and practicing skills in a time limited setting are offered. Transitional support is then utilized with the ultimate goal of participants acquiring independent community fitness access.

Yoga: This program is offered by a certified Yoga instructor and TR. It focuses on both spiritual and physical domains of Therapeutic Recreation. The weekly class incorporates breathing techniques, exercise and meditation. Goals may include multiple health and wellness benefits.

Smart Start: This program is designed for participants who are physically deconditioned and/or require increased support with physical activity, due to cognitive deficits. The outcomes for our clients are increased functional strength, improved cardiovascular conditioning, to learn how to safely use resistance equipment, develop functional fitness skills and to make connections to community-based resources.

Photovoice: This program provides the opportunity for participants to creatively document their views, perceptions and concerns with photos. Photovoice breaks past language and traditional communication barriers that often prevent people from self-expression. The goal is to create photographic evidence and symbolic representations to offer insight, share experiences and help others see the world through other's eyes.

Stretch and Strengthen: This program allows participants to work on flexibility, strength and balance at your own pace. Participants are led in low impact body weight exercises, breathing techniques and relaxation practices.

St. Joseph's Healthcare Hamilton | Connect Mental Health and Addiction Outpatient Programs

Outpatient Referral Form for Providers

Phone: (905) 522-1155 Ext. 36499 Fax: (905) 389-3815 Email: connectmhap@stjoes.ca

Client/Patient Information

* Last Name:
* Legal Name:
Preferred Name:
Date of Birth: (yyyy/mm/dd)
Health Card Number:
VC:
Address:
Unit:
City:
Postal Code:
Gender: ☐ Male ☐ Female ☐ Transgender ☐ Prefer not to answer
☐ Prefer to self-identify:
*Primary Contact Phone: ☐ Mobile ☐ Landline
Can a message be left at this number? ☐ No ☐ Yes
Can we use text for communication? ☐ No ☐ Yes
If yes, number to text:
Can we use email for communication? ☐ No ☐ Yes
If yes, email address:
Alternate Contact Information:
Consent to contact? ☐ No ☐ Yes
Community Treatment Order? ☐ No ☐ Yes (If Yes, Include CPT & CTO)
Capable to make treatment decisions? ☐ No ☐ Yes (If No, include Form 33)
Substitute Decision Maker (SDM): ☐ No ☐ Yes (If Yes, include Form 33)
SDM Name:
Relationship: Phone:
Emergency Contact Name:
Relationship: Phone:

Referral Source Information

* Provider Referring:
Facility:
Specialty: Billing #:
Contact Person:
* Phone: Backline:
Fax:
Does client have a family physician? ☐ No ☐ Yes
Name of family physician:
Is family physician part of FHT? ☐ No ☐ Yes
If yes, have internal services been accessed?
☐ No ☐ Yes (Please attach records)

Consent

* Patient is aware of this referral and has consented to their health information being collected from various sources to make decisions regarding care. ☐ No ☐ Yes

Special Needs

Preferred Language: ☐ English
☐ Other
Is an interpreter required? ☐ No ☐ Yes
☐ Cognitive Impairment ☐ Hearing Impairment
☐ Sight Impairment ☐ Mobility/Fall Risk
☐ Sensory (smell/light) ☐ Unable to attend clinic
☐ Other:

Presenting Concerns/Referral Goal (i.e. diagnostic clarification, medication review, 2nd opinion, treatment)

* Reason for Referral: ☐ New Request ☐ Re-referral * Indicate Urgency: ☐ Urgent (< 2 weeks) ☐ Non-urgent
* Please describe presenting problems, current symptoms, and reason for urgency:

How long has this been a concern? ☐ Less than one month ☐ 1-6 months ☐ More than 6 months
Currently receiving treatment for this concern? ☐ No ☐ Yes
If yes, Provider name, discipline and type of treatment:

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Client/Patient Name: _____

Past/Present Psychiatric Diagnoses

	Past	Present		Past	Present
Bipolar Disorder	☐	☐	Anxiety Disorder	☐	☐
Schizophrenia/Schizoaffective	☐	☐	Depression	☐	☐
Eating Disorder	☐	☐	Psychosis (Hallucinations/Delusions)	☐	☐
Personality Disorder _____	☐	☐	Neurocognitive Disorder	☐	☐
Post Traumatic Disorder	☐	☐	Other: _____	☐	☐

Treatment History - (Please attach assessments, discharge summaries, progress notes from other agencies, hospitals or therapies)

Hospital admission(s) for: mental health concerns: ☐ No ☐ Yes addiction concerns: ☐ No ☐ Yes

ER visit(s) for: mental health concerns: ☐ No ☐ Yes addiction concerns: ☐ No ☐ Yes

Involvement with other agencies and/or therapy? ☐ No ☐ Yes

Please provide details of when, where and outcome of treatment history. Information is necessary to complete intake process.

Medical History (Please attach relevant CURRENT and PAST medical information, i.e. respiratory, cardiac, metabolic)

Please Describe:

Indicate all that apply:

☐ Acquired Brain Injury ☐ Developmental Disability ☐ Neurological Disorder ☐ Pregnant/Post-partum Due Date: _____

Substance Use

Use alcohol or drugs weekly or more often? ☐ No ☐ Yes

Spend a lot of time either getting, using or recovering from the effects of alcohol/drugs? ☐ No ☐ Yes

Continue to use alcohol or drugs even though it's causing problems? ☐ No ☐ Yes

Experience withdrawal problems or use substances to stop being sick? ☐ No ☐ Yes

Substance: _____ Amount Used: _____ Frequency: _____

Substance: _____ Amount Used: _____ Frequency: _____

Substance: _____ Amount Used: _____ Frequency: _____

Risk Issues (Please check all that apply)

Risk Issue	Yes	No	If Yes, when?	Details
Suicide Attempt	☐	☐		
Suicide Ideation	☐	☐		
Deliberate Self-harm	☐	☐		
Homicidal Threats/Ideation	☐	☐		
Violent/Aggressive Behaviour	☐	☐		
Legal Involvement	☐	☐		
Homelessness/Risk of	☐	☐		
Lives Alone	☐	☐		
Other:				

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Client/Patient Name: _____

Medication/Supplements: (PSYCHIATRIC and NON-PSYCHIATRIC medications including opiate replacement therapies. Please attach additional information if required.)

Medication	Dose/Frequency	Current	Past	Start Date	Response/Adverse Effects
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		

Eating Disorders Clinic Referrals: Please complete the following sections and submit with the required investigations

Please note the SJHH Eating Disorders Clinic is an outpatient clinic and does not have day hospital or inpatient treatment and does not offer meal supervision. Referral is for consultation/recommendations. Treatment will be offered if appropriate. Considerations include medical stability, symptom severity, psychiatric comorbidity. Clients must have a BMI over 16.

Current Physical Status: Please complete in full as this information is necessary to determine appropriate treatment

Height (cm): _____ Weight (kg): _____ BMI: _____

Weight Loss: ☐No ☐Yes Weight Gain: ☐No ☐Yes Please indicate change: _____ kg over _____ (time period)

Has this patient ever received treatment for his/her eating disorder? ☐No ☐Yes

If yes, where and when: _____

Current Symptoms: Please check all that apply and include frequency. Information is necessary to determine appropriate treatment.

Symptom	Yes	No	Frequency	Symptom	Yes	No	Frequency
Restriction	☐	☐		Diet Pills	☐	☐	
Binge Eating	☐	☐		Insulin Restriction	☐	☐	
Vomiting	☐	☐		Diuretics	☐	☐	
Laxatives	☐	☐		Extreme distress with weight and shape	☐	☐	
Extreme Exercise	☐	☐		Other:	☐	☐	

Current Investigations: Mandatory - Please attach results from within the last three months.

☐ ECG	☐ Calcium	☐ Glucose	☐ AST	☐ Alkaline Phosphatase
☐ CBC & Diff	☐ Magnesium	☐ Urea	☐ ALT	☐ Vitamin B12
☐ Electrolytes	☐ Phosphate	☐ Creatinine	☐ GGT	☐ GGT
☐ Ferritin	☐ If Binge Eating is the <u>only</u> reported symptom, please <u>also</u> complete Fasting Lipids			

If your patient is in crisis and requiring immediate help, please contact your local crisis service or direct them to your nearest emergency department. In Hamilton, contact COAST (905-972-8338) or Barrett Centre (Toll Free 1-844-777-3571), in Haldimand Norfolk contact CAST (1-866-487-2278), in Niagara contact COAST Niagara (1-866-550-5205, ext. 1), in Brant contact Integrated Crisis Services; St. Leonard's (519-759-7188 or 1-866-811-7188), and in Halton contact COAST Halton (1-877-825-9011).

_____ Referral Source Signature

_____ Date Signed (yyyy/mm/dd)

Physical Activity Readiness
Questionnaire - PAR-Q
(revised 2002)

PAR-Q & YOU

(A Questionnaire for People Aged 15 to 69)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: check YES or NO.

YES	NO		
☐	☐	1.	**Has your doctor ever said that you have a heart condition <u>and</u> that you should only do physical activity recommended by a doctor?**
☐	☐	2.	**Do you feel pain in your chest when you do physical activity?**
☐	☐	3.	**In the past month, have you had chest pain when you were not doing physical activity?**
☐	☐	4.	**Do you lose your balance because of dizziness or do you ever lose consciousness?**
☐	☐	5.	**Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?**
☐	☐	6.	**Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?**
☐	☐	7.	**Do you know of <u>any other reason</u> why you should not do physical activity?**

If you answered

YES to one or more questions

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

- You may be able to do any activity you want — as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful for you.

NO to all questions

If you answered NO honestly to <u>all</u> PAR-Q questions, you can be reasonably sure that you can:

- start becoming much more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.
- take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

→

DELAY BECOMING MUCH MORE ACTIVE:

- if you are not feeling well because of a temporary illness such as a cold or a fever – wait until you feel better; or
- if you are or may be pregnant – talk to your doctor before you start becoming more active.

PLEASE NOTE: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

NOTE: If the PAR-Q is being given to a person before he or she participates in a physical activity program or a fitness appraisal, this section may be used for legal or administrative purposes.

"I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction."

NAME _____

SIGNATURE _____ DATE _____

SIGNATURE OF PARENT or GUARDIAN (for participants under the age of majority) _____ WITNESS _____

Note: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the seven questions.

St. Joseph's Healthcare Hamilton

Authorization for Disclosure of Personal Health Information

Information and Instructions

1. This authorization is valid for three (3) months from date of signature and must contain:
   - the original signature of the patient or substitute decision maker (SDM)
   - the legal representative if the patient is deceased
   - the signature of the witness to the patient or SDM signature
2. Requests for release of information must be dated after treatment dates.
3. Deliver completed request to appropriate Release of Information Specialist (address below)

For information about our privacy protection practices visit our website at www.stjoes.ca/privacy

Patient Identification

Name: _____ Date of Birth: _____
First Last yyyy/mm/dd

Address: _____
Street City Postal Code

I the undersigned authorize: _____ to
Print name of Health Information Custodian/Facility

Disclose personal health information to:

_____
Print Name and address of person/facility requesting the information

_____ _____ _____
Address City Postal Code

Purpose of Disclosure: ❑ Healthcare ❑ Legal Proceeding ❑ Insurance

❑ Other: _____

The Personal Health Information I authorize to be disclosed:

❑ Discharge Summary:

❑ Information Relating to: _____

❑ Other: _____

_____ _____ _____
Signature Print Name Relationship to Patient
(state relationship which authorizes this consent to disclose)

_____ _____ _____
Witness Signature Print Name Date (yyyy/mm/dd)

THIS AUTHORIZATION MAY BE RESCINDED OR AMENDED IN WRITING AT ANY TIME PRIOR TO THE EXPIRATION DATE (3 MONTHS) EXCEPT WHERE ACTION HAS BEEN TAKEN IN RELIANCE ON THIS AUTHORIZATION

Charlton Campus
50 Charlton Ave., East
Hamilton, ON, Canada L8N 4A6
Tel: 905.522.1155

King Campus
2757 King Street East
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West 5th Campus
100 West 5th Street
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Member, St. Joseph's Health System
Teaching Campus of the Faculty of Health Sciences, McMaster University
www.stjoes.ca

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