Assertive Community Treatment Team (ACTT)
Referral Form

Please submit to: ACTT at 185 Robinson Street, Suite 240, Simcoe, ON N3Y 5L6
Attention: Intake Coordinator Phone: (519) 426-9980 Fax: (519) 426-0971

Please submit to: ACTT at 185 Robinson Street, Suite 240, Simcoe, ON N3Y 5L6

Name _____

Current Address _____
Number Street Apt. Number

_____
Town/City Province Postal Code

Home Address _____
Number (Municipal number) Street Apt. Number

_____
Town/City Province Postal Code

Phone Numbers: **Home** ( ) _____ **Work** ( ) _____

Is it OK to leave a message? **Home** yes ____ no ____ **Work** yes ____ no ____

Health Card Number _____ **vc** ____ **Date of Birth** _____
Day Month Year

Gender: **M** **F** **Preferred Language** _____

Family/Significant Other _____ **Phone Number** (H) _____

Is it OK to leave a message? yes ____ no ____ (W) _____

Alternative Contact Person _____ **Phone Number** _____

… whose primary diagnosis is a psychotic illness (excluding Substance-Induced Psychosis, but not excluding Substance Abuse as an additional diagnosis)…

Reason for Referral _____

_____
_____
_____
_____
_____

Referral Name _____ **Phone Number** ( ) _____

List of Current Medications (including dosages):

_____ _____
_____ _____
_____ _____
_____ _____

Mental Health Diagnosis: (DSM) _____

_____
_____

Any current medical/physical health concerns: _____

_____

Substance Use (drugs, alcohol) (Severity): _____

_____
_____

…whose mental health service needs are high, as defined by 2 or more of these…	
☐ 60 or more days in hospital OR 5 or more ER visits OR 3 or more hospitalizations in the last year	☐ High risk or or recent history of criminal justice involvement
☐ Coexisting substance abuse disorder	☐ Severe or intractable major symptoms
☐ Would require institutional placement without intensive outpatient services	☐ Otherwise unable to participate in office-based services

…who are unable to cope well in the community between crises…(indicate serious difficulty with any of following:)	
☐ Finances	☐ Personal care
☐ Household management, evictions	☐ Use of transportation
☐ Family relationships	☐ School/Vocational activities
☐ Interpersonal skills	☐ Social, leisure activities
☐ Other	☐

Indicate any history of the following:	
☐ Violence toward self	☐ Violence toward others
☐ Violence toward property	☐ Sexual assault
☐ Fire setting	☐ Development delay
☐ Head injury	

Indicate involvement with any of the following:	
☐ counseling services	☐ addiction services
☐ vocational services	☐ Children's Aid Society
☐ probation/parole	☐ housing program

…and who are willing (or whose substitute consent-giver at the time of the referral is willing) to accept service provision by ACTT

Substitute Consent Giver and Relationship: _____

Considerations for exclusion are: Severe Developmental Delay, Head Injury, Repetitious Violence, Current Adequate Outpatient or Community Follow-up.

Psychiatrist Name: _____ Phone Number _____

Family Doctor Name: _____ Phone Number _____

Has this referral been discussed with the:

a) client Yes_____ No_____
b) family/significant other Yes _____ No _____
c) treating psychiatrist/physician Yes _____ No _____

Has this client completed a "release of information" Yes _____ No _____ (Attach please)

Referral Source Signature: _____Position:_____

AND/OR

Client Signature: _____

Date: _____

Another Service provided off site by:

St. Joseph's Healthcare Hamilton

Assertive Community Treatment Team of Haldimand-Norfolk

Member, St Joseph's Healthcare System

Affiliated with the Faculty of Health Sciences, McMaster University

185 Robinson Street, Suite 240

Simcoe, ON N3Y 5L6

Local: 519-426-9980 Fax: 519-426-0971 Toll Free: 1-866-768-4818