COMMUNITY REFERRAL TO MENTAL HEALTH & ADDICTIONS

MHA-REF-001

Mental Health and Addictions

For referrals to **Humberwood** or **Grace Centre**, please complete **Referral to Adult Addictions Inpatient Ref406**

REFERRAL CLASS & ROUTING

Class: ◯ Incoming Referral ◯ Internal Referral

Referral: ☐ Override Restrictions

Zone: ◯ Central ◯ Eastern Rural ◯ Eastern Urban ◯ Labrador-Grenfell ◯ Western

Referral Reason: ◯ Psychiatry ◯ Counselling & Other Community-Based Services

If Referral Reason = Psychiatry

Note: Referral Source must be a Physician or Nurse Practitioner

Reason (check all that apply):

☐ Treatment Recommendations
☐ Diagnostic Clarification
☐ Medication Review

_____

If Referral Reason = Counselling & Other Community-Based Services

Requested service — Central:

☐ Mental Health Counselling ☐ Addictions Counselling ☐ FACTT ☐ Case Management ☐ Rapid Access Addiction Treatment
☐ Clinical Sexology ☐ Provincial Groups ☐ Other, please comment _____

Requested service — Eastern Rural:

☐ Mental Health Counselling ☐ Addictions Counselling ☐ FACTT ☐ Rapid Access Addiction Treatment ☐ Clinical Sexology
☐ Therapeutic Recreation ☐ Provincial Groups ☐ Other, please comment _____

Requested service — Eastern Urban:

☐ Mental Health Counselling ☐ Addictions Counselling ☐ FACTT ☐ ACTT ☐ Early Psychosis
☐ Rapid Access Addiction Treatment ☐ Housing Division ☐ Clinical Sexology ☐ Occupational Therapy ☐ CAST
☐ Traumatic Stress Services ☐ Geriatric Psychiatry Day Program ☐ Therapeutic Recreation ☐ Provincial Groups
☐ Other, please comment _____

Requested service — Labrador-Grenfell:

☐ Mental Health Counselling ☐ Addictions Counselling ☐ FACTT ☐ Early Psychosis ☐ Rapid Access Addiction Treatment
☐ Clinical Sexology ☐ Provincial Groups ☐ Other, please comment _____

Requested service — Western:

☐ Mental Health Counselling ☐ Addictions Counselling ☐ FACTT ☐ Early Psychosis ☐ Rapid Access Addiction Treatment
☐ Supported Employment Program ☐ Clinical Sexology ☐ Provincial Groups ☐ Other, please comment _____

If FACTT selected — FACT Team (by zone)

Central: ◯ FACT Gander ◯ FACT Grand Falls _____

Eastern Rural: ◯ FACTT Bonavista/Clarenville ◯ FACTT Rural Avalon ◯ FACTT Burin _____

Eastern Urban: (no sub-team selection required)

Labrador-Grenfell: ◯ FACTT HVGB & Sheshatshiu ◯ FACTT Labrador West ◯ FACTT St. Anthony & South _____

Western: ◯ FACTT Deer Lake ◯ FACTT Corner Brook ◯ FACTT Stephenville _____

If Case Management selected (Central only) — Location:

◯ Baie Verte ◯ Springdale ◯ Lewisporte ◯ Glovertown ◯ Brookfield _____

If Zone = Eastern Rural — Which area? ◯ Peninsulas ◯ Rural Avalon _____

CLIENT CONTACT INFORMATION

Is client aware of referral?

◯ Yes ◯ No _____

Best way to contact client: ◯ Phone ◯ Contact address _____

If Phone — Can a message be left? ◯ Yes ◯ No _____

If Contact address — Can a letter be sent? ◯ Yes ◯ No _____

Contact Information for Next of Kin/Guardian:

First name: _____ Last name: _____

Contact number: _____

Relationship: _____

Any accommodations required? (translation, etc.) ◯ Yes ◯ No

If Yes — What type? _____

CLINICAL INFORMATION

Presenting concern:

_____

Previous Mental Health, Addictions, and/or Psychiatric Services:

◯ Yes ◯ No ◯ Unknown

If Yes:

Provider: _____

Diagnosis: _____

Last Date Seen: _____

Other services involved: _____

Substance use: ◯ Current ◯ Past ◯ None

If Current or Past — Describe: _____

Suicidal Ideation: ◯ Current ◯ Past ◯ None

If Current:

Current Plan: ◯ Yes ◯ No

Additional Details: _____

If Past:

Previous Suicide Attempts: ◯ Yes ◯ No

Additional Details: _____

Aggression (verbal or physical): ◯ Current ◯ Past ◯ None _____

If Current or Past — Describe: _____

Urgent: ◯ Yes ◯ No

If Yes — Reason: _____

Medication trials for current concern: ◯ Yes ◯ No

If Yes:

Trial 1: _____

Trial 2: _____

CLINICAL INFORMATION (continued)

Other medications and/or RELEVANT medical conditions:

If Requested Service = Provincial Groups

What group are you referring to?

Presenting issues and goals:

What is the client's readiness to change?

What services have been previously availed of? Previous group based therapy?

Any issues or concerns that may impact ability to participate in groups?

Is the person able to attend the group at the time offered and for the duration of the group?

◯ Yes ◯ No _____

Any Barriers?

If offered virtually — does the person have access to the technology needed?
(internet access, device with camera/microphone/speaker, headset)

◯ Yes ◯ No _____

Do they have a private space in which they can attend?

◯ Yes ◯ No _____

Comments: