South Eastern Ontario Addictions & Mental Health Service Access Form

Please check one of the following:

HASTINGS & PRINCE EDWARD COUNTIES	LENNOX & ADDINGTON	KINGSTON & FRONTENAC	LANARK COUNTY	LEEDS & GRENVILLE	REGIONAL TERTIARY SERVICES
☐ **Open Line Open Mind** Tel: 310-OPEN Fax: 613-961-2528	☐ **L&A Addiction and Community Mental Health Services** Tel: 613-354-7521 Fax: 613-354-7524	☐ **Frontenac Community MH&A Services** Tel: 613-544-1356 Fax 613-544-2346 ☐ **Hotel Dieu Hospital, Mental Health Services** Tel:613-544-3440x2551 Fax: 613-548-6095	☐ **Lanark County Mental Health** Tel: 613-283-2170 Fax 613-283-9018 ☐ **TriCounty Addiction Services** Tel: 613-283-7723 Fax: 613-283-9407	☑ **Central Intake** Tel: 613-342-2262 866-499-8445 Fax: 613 342 4969 ☐ **TriCounty Addiction Services** Tel: 613-345-7453 Fax: 613-345-7761	☐ **Providence Care, Mental Health Services** Tel: 613-546-1101 Fax: Please see below

REFERRAL SOURCE

Agency / Source: _____ Telephone: _____

Fax: _____

Date of Referral (yyyy/mm/dd): _____ Physician Billing #: _____

Identification of first language:
☐ English ☐ French ☐ Other: _____

☐ **Check here to indicate that we can contact the most appropriate service for your client and redirect the referral**

☐ **Check here to indicate that information can be shared with GP**

CLIENT INFORMATION

Name: _____

Address: _____

City: _____ Postal Code: _____

Preferred Contact # _____ Alternate Contact # _____

Can message be left at this number? ☐ Yes ☐ 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): _____

COMMUNITY SERVICES – Service Requested
- ☐ Community Addictions or Mental Health Support Services
- ☐ Psychiatric Consultation ***(Physician referral only)***
- ☐ Housing
- ☐ Assertive Community Treatment Team (ACTT)
- ☑ Other (please specify):

PROVIDENCE CARE (Tertiary Services) – Service Requested
- ☐ Personality Disorder Service (Fax: 613-542-1400)
- ☐ Mood Disorder Specialty Outpatient (Fax: 613-540-6114)
- ☐ ACTT & Case Management (Fax: 613-540-6114)
- ☐ Community Treatment Order Program (Fax: 613-540-6139)
- ☐ Dual Diagnosis Consultation Outreach Team (Fax: 613-530-2212)

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.e. Pregnancy, Gambling, Concurrent disorders*	☐	☐		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: _____ **Date** (yyyy/mm/dd): _____

Clear Form