

# Assertive Community Treatment Team Central Intake Community Mental Health Program

The Assertive Community Treatment Team (ACTT) helps people with complex, long-term and serious psychiatric illness involving multiple hospitalizations of a minimum of 50 days in past year or 150 days over 3 years. An individual, the family or the current service provider can make referrals. A central intake team reviews referrals for all Ottawa area ACTT. A client assessment will be done to determine eligibility for ACTT services.

## Services include:

- Identify and achieve individual goals (*such as life skills, vocational, education, financial, recreation, etc*)
- After hours emergency services for clients in the service
- Symptom assessment, management and education
- Supportive counselling
- Medication education, prescription administration and monitoring

## Please send to:

### *For ACT teams*

c/o Intake Coordinator

1145 Carling Avenue

Ottawa ON K1Z 7K4

Tel: 613.722.6521 ext. 7325

Fax: 613.739.8400

**PLEASE NOTE THAT ALL  
INCOMPLETE REFERRAL FORMS WILL BE RETURNED  
TO SENDER**



# Assertive Community Treatment Team Central Intake

## CLIENT CONSENT

For Long-Term Community Mental Health Support Referrals

The Assertive Community Treatment (ACT) Teams and the Intensive Case Management Services work in collaboration with each other. To make the process easier for you, we request your permission to discuss your referral at our joint monthly meetings and with other service providers involved in your care.

*Please sign below giving your consent.*

Date: \_\_\_\_\_

Client name: \_\_\_\_\_  
(Please print)

Client signature: \_\_\_\_\_

\_\_\_\_\_  
(If other than the patient, state relationship to the patient. Please sign and print name.)

Witness name: \_\_\_\_\_  
(Please print)

Witness signature: \_\_\_\_\_

## MHCSS – Partner in Case Management

Canadian Hearing Society  
Horizons Renaissance Inc.  
Ottawa Salus Corporation  
Project Upstream  
Somerset West Community Health Centre

Canadian Mental Health Association, Ottawa  
Ottawa Carleton Immigrant Services  
Pinecrest Queensway Health & Community Services  
Royal Ottawa Health Care Group



# Assertive Community Treatment Team Central Intake

Date of referral: DD / MM / YY

## SECTION 1: Client information

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Marital status: \_\_\_\_\_

Date of birth: DD / MM / YY

Sex:  F  M

Address: \_\_\_\_\_

Telephone: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Source of income: \_\_\_\_\_

Aboriginal:  Yes  No

Language:  English  French  Other: \_\_\_\_\_

Health card #: \_\_\_\_\_

Emergency contact: \_\_\_\_\_

Highest level of education: \_\_\_\_\_

## SECTION 2: Source of referral

Primary referral source: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Fax: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

E-mail address: \_\_\_\_\_

# Assertive Community Treatment Team Central Intake

## SECTION 3: Reason for referral

Explain briefly:

### PSYCHIATRIC DIAGNOSIS AND HEALTH:

Diagnosis: PRIMARY: \_\_\_\_\_ SECONDARY: \_\_\_\_\_

Physical problems: \_\_\_\_\_

Age of onset of illness: \_\_\_\_\_

**CURRENT MEDICATIONS:** *please use separate sheet*

**HOSPITALIZATIONS:** *please include dates, duration and institution. Please add separate sheet, if required.*

Age of first hospitalization: \_\_\_\_\_

DATE	DURATION	INSTITUTION

**HOMELESSNESS:** *please include dates over the past two years*

### SUBSTANCE ABUSE:

Does the client struggle with substance abuse?  Yes  No

If yes, specify:

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## FUNCTIONAL ABILITIES:

	Yes	No
Meets basic needs ( <i>housing, food</i> )	<input type="radio"/>	<input type="radio"/>
Carries out activities of daily living required for basic functioning in the community ( <i>ex. : getting to and from places, medical care, personal hygiene</i> )	<input type="radio"/>	<input type="radio"/>
Maintains safe housing ( <i>no eviction nor loss of housing</i> )	<input type="radio"/>	<input type="radio"/>
Maintains vocational activity ( <i>school, volunteering, or employment</i> )	<input type="radio"/>	<input type="radio"/>
Family and/or social network involvement	<input type="radio"/>	<input type="radio"/>
History of suicide attempts	<input type="radio"/>	<input type="radio"/>
History of harm to others	<input type="radio"/>	<input type="radio"/>
Has person been declared financially incompetent?	<input type="radio"/>	<input type="radio"/>
Does he/she have a Public Guardian and Trustee?	<input type="radio"/>	<input type="radio"/>
Has person been declared incompetent to make treatment decisions?	<input type="radio"/>	<input type="radio"/>
Substitute decision maker ( <i>name, relationship and telephone</i> )?	<input type="radio"/>	<input type="radio"/>

\_\_\_\_\_

Name

\_\_\_\_\_

Relationship

\_\_\_\_\_

Telephone

## LEGAL:

Dates and duration of incarcerations over past 2 years:

Reasons/charges: \_\_\_\_\_

Court Order: \_\_\_\_\_

Is person under a Community Treatment Order?       Yes       No

Date of issuance: DD / MM / YY      Issuing physician: \_\_\_\_\_

Has person been declared Not Criminally Responsible?       Yes       No

## OTHER SERVICES:

NAME	ADDRESS	TELEPHONE

# Assertive Community Treatment Team Central Intake

Has this referral and potential assessment been discussed with:

Client  Yes  No

Family  Yes  No

Other (specify): \_\_\_\_\_

**PLEASE ENSURE THAT ALL PERTINENT INFORMATION IS INCLUDED WITH REFERRAL. PLEASE CHECK BOXES.**

- consent to disclose health information signed by client
- admission/discharge summaries of past psychiatric hospitalizations over the past 2 years
- consultation reports or other significant documents within past 2 years
- case and or social histories

## **VIOLENCE / AGGRESSION ASSESSMENT CHECK LIST (VACC)**

Known history of violence  Yes  No

### **BEHAVIOUR AND RISK**

Please indicate if the patient has recently exhibited any of the following type of behaviour below:

- Uncooperative
- Verbal abuse
- Hostile/attacking objects
- Threats
- Assaultive/combatative
- No aggressive behaviour exhibited

**Known risk factors/triggers** (enter 'none' if there are no known risk factors/triggers or if this question is not applicable)

**Mitigation strategies for Known risk factors/triggers** (enter 'none' if there are no known mitigation strategies or if this question is not applicable)

Level of risk  low  moderate  high

**Current risk mitigation strategies/intervention** (enter 'none' if there are no risk mitigation strategies/intervention)