THE / LE ROYAL

Ottawa Region

Assertive Community Treatment Team (ACTT) Referral Form

INSTRUCTIONS

General instructions

1. Please ensure that you have completed the referral form in full to ensure that the applicant qualifies for this service.
2. PRINT/TYPE all answers clearly.
3. Should you have any questions, please call the Community Mental Health Program (CMHP) at 613-722-6521 ext. 7325.
4. Mail or fax the completed application form to the address and fax number below:

ACTT Central Intake
Community Mental Health Program (CMHP)
2121 Carling Avenue, Suite 201
Carlingwood Shopping Centre
Ottawa, ON K2A 1H2

Phone: 613-722-6521 ext. 7325

Fax: 613-739-8400

The ACTT model is-based on a recovery-oriented, long-term, community-based intensive case management service with specific eligibility and admission criteria. It is important to note that referrals to ACTT services should not be made with the expectation that the referral will facilitate an early discharge from an inpatient hospital admission. Other community supports should be considered in discharge planning until ACTT services are able to admit clients considered appropriate for ACTT services.

Exclusions

These clients are not considered appropriate for ACTT services:

1. Primary diagnosis of personality disorder, substance use disorder and developmental disability (as these are more appropriately treated by other specialized services).
2. Client is too violent or has other significant risks that would affect safe community care.
3. Non-compliance to medications adherence in itself is not a reason for ACTT.

Our teams

Catherine Flexible Assertive Community Treatment Team (FACTT)

Bank Flexible Assertive Community Treatment Team (FACTT)

Carlington Assertive Community Treatment Team (ACTT)

Pinecrest-Queensway Assertive Community Treatment Team (ACTT)

Montfort Hospital — Équipe Communautaire de Traitement Intensif (ÉCTI) — Francophone clients

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

MARCH 2026

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INTAKE SCREENING TOOL — REQUIRED

1. **Aged 18 +** ☐
2. **Axis I diagnosis** ☐ Examples: bipolar disorder, schizophrenia or schizoaffective disorder
3. **The applicant is willing to participate in the frequency and intensity of ACTT services** ☐
4. **Heavy system use:**
   - ☐ Hospital admissions more than 50 days in past two years (preferred)
   - ☐ Increased use of medical/support services in the past six months (family doctor, emergency department, outpatient psychiatry and crisis services)
   - ☐ Has not been successful in less intensive conventional mental health community services (including case management)
5. **At least one of the following:**
   - ☐ Poor medication adherence and/or treatment resistant: _____
   - ☐ Severe persistent functional impairment: _____
   - ☐ Inability to consistently perform the range of practical daily living tasks required for basic adult functioning in the community except with significant support (e.g., personal care, meal planning/cooking, homemaking tasks, budgeting, attending appointments)
   - ☐ Difficulty with employment/vocational issues or carrying out the homemaker role (e.g., childcare tasks)
   - ☐ Housing problems
   - ☐ Inability to maintain a safe living situation (e.g., homelessness, at risk of homelessness, multiple evictions, difficult to house)
   - ☐ Needs supportive housing
   - ☐ Able to live in more independent housing if intensive support is available
6. **Additional factors:**
   - ☐ Addictions: Co-existing substance abuse disorder during the past six months or longer
7. **Legal involvement:**
   - ☐ In the past 2 years: _____
   - ☐ Recurring criminal justice involvement, Not Criminally Responsible (NCR)/Ontario Review Board, or court diversion/involvement: _____

NOTE: in the event of any conflicting opinions between ACTT and the referring source in respect to a primary diagnosis and primary symptom presentation, ACTT shall exercise due diligence in gathering information from all available resources and ACTT's determination of the diagnosis at time of referral shall be viewed as definitive and shall determine acceptance or refusal of the referral.

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INTAKE SCREENING TOOL — REQUIRED

Personal information

First name: _____ Last name: _____ Preferred name: _____

Date of birth: _____ (DD/MM/YYYY) Language(s) spoken: ☐ English ☐ French ☐ Other: _____

Preferred pronouns (check all that apply):

☐ She/her ☐ He/him ☐ They/them ☐ Other: _____ ☐ Prefer not to disclose

Gender identity (check all that apply):

☐ Woman ☐ Man ☐ Trans woman ☐ Trans man ☐ Non-binary ☐ Two-spirit
☐ Other: _____ ☐ Prefer not to disclose

OHIP/IUC number (if known): _____ Version: _____ Expiry: _____ (YYYY/MM/DD)

Contact information

Street address (on discharge): _____

City: _____ Province: _____ Postal code: _____

Telephone number: _____

Current status

Who does the applicant presently live with? _____

If the applicant does not have a phone or is otherwise difficult to reach, is there someone with whom he or she is in contact that we can call in order to reach him or her?

Name: _____ Telephone: _____

Relationship to applicant: _____

Can a message be left at the phone number provided? ☐ Yes ☐ No

Does the applicant have a Substitute Decision Maker (SDM) for treatment? ☐ Yes ☐ No
If yes, please provide their name, and contact information:

Name: _____ Telephone: _____

Health information

Is the applicant capable to consent to treatment? ☐ Yes ☐ No

Is the applicant capable to consent to collection/use/disclosure of Protected Health Information (PHI)? ☐ Yes ☐ No

Does the applicant have a Trustee for finance? ☐ Yes ☐ No
If yes, please provide their name, address and contact information:

Name: _____ Telephone: _____

Address: _____

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Referral source information (please complete in full)

Agency: _____

Last name: _____ First name: _____

Street address: _____

City: _____ Province: _____ Postal code: _____

Telephone: _____ Fax: _____ Email: _____

Reason for referral

Please describe *clearly and as specifically as possible* the reason(s) for the referral to ACTT. What is the present difficulty and in which area(s) could the applicant benefit from support?

What is the applicant's mental health diagnosis? Please be specific and detailed as possible:

Primary: _____

Secondary: _____

What was the age of onset of this diagnosis? _____

How long has the applicant been experiencing mental health difficulties (i.e., length of time)? _____

Does the applicant have any other illnesses/disability such as:

- Concurrent disorders (substance use and mental illness): ☐ Yes ☐ No ☐ Unknown
- Dual diagnosis (developmental disability and mental illness): ☐ Yes ☐ No ☐ Unknown
- Neurological (e.g., head/brain injury, epilepsy, Parkinson's, cognitive disorders, etc.): ☐ Yes ☐ No ☐ Unknown
- Other chronic illness/physical disabilities (e.g., hypertension, diabetes, allergies: ☐ Yes ☐ No ☐ Unknown

If yes to any of the above, please describe:

Pharmacy information

Please attach medication list to this application or list below. List attached? ☐ Yes ☐ No

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Housing status

What type of housing does the applicant presently live in?

- ☐ Community Homes for Opportunity (CHO)
- ☐ Correctional/probationary Facility
- ☐ Hospital
- ☐ Supportive housing
- ☐ Senior's residence, or retirement home
- ☐ Market rent housing
- ☐ Long-term care facility
- ☐ Private house/apt — client owned market
- ☐ Rent
- ☐ Subsidized non-profit housing
- ☐ Rent supplemental housing
- ☐ Private house/client owned apartment or condo
- ☐ No fixed address
- ☐ Shelter

Does the applicant currently live in housing with Pest infestation? Response is mandatory. ☐ Yes ☐ No

Is the applicant currently homeless or at risk of becoming homeless?

☐ Yes ☐ No If yes, please explain:

Income, Employment and Education

What is the applicant's primary source of income?

☐ Ontario Disability Support Program (ODSP) ☐ Employment pension ☐ Employment insurance

☐ Family ☐ Canada Pension Plan (CPP)/ Old Age Security (OAS) ☐ Guaranteed Income Supplement (GIS)

☐ Social assistance (e.g., Ontario Works) ☐ Disability assistance ☐ No source of income/unemployed

☐ Employed (full-time/part-time/casual) ☐ Other: _____

What is the applicant's current employment status?

☐ Full-time ☐ Part-time ☐ Casual work ☐ Not employed ☐ Retired

☐ Volunteering: _____

If applicant is employed, please describe the type of work and how many hours per week:

What is the highest grade/level of education the applicant has attained?

- ☐ Elementary/junior high school
- ☐ Secondary/high school
- ☐ Post-secondary (college/university)
- ☐ Unknown: _____

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Applicant's support needs

Applicant requires support with (check all that apply):

☐ Managing specific symptoms of serious mental health illness ☐ Developing daily living skills

☐ Finances ☐ Housing needs ☐ Educational opportunities ☐ Occupational/employment/vocation

☐ Substance abuse/addictions issues ☐ Legal issues ☐ Social (supports and peer supports) ☐ Relationships

☐ Other: _____

List of current strengths/resources (check all that apply)

Economic resources: ☐ Employment ☐ Ontario Disability Support Program (ODSP)/Canada Pension Plan (CPP)

☐ Housing ☐ Transportation ☐ Financial

Education/skill resources: ☐ Language/skills ☐ Education ☐ Job skills ☐ Interpersonal skills

Person resources: ☐ Parent(s) ☐ Sibling(s) ☐ Friend(s) ☐ General practitioner ☐ Child(ren) ☐ Relative(s)

☐ Crisis plan

Personal strengths: ☐ Empathy ☐ Judgment ☐ Appearance ☐ Responsibility ☐ Insight ☐ Adaptability

☐ Thought Clarity ☐ Health ☐ Tolerance ☐ Resourcefulness

Notes:

Hospitalizations

Please provide an estimate of total number of days that they have spent in hospital (inpatient units) due to mental health difficulties within the past 2 years.

NAME OF HOSPITAL	DATE (DD/MM/YYYY)	DURATION

Notes:

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VIOLENCE/AGGRESSION ASSESSMENT CHECKLIST (VAAC) — REQUIRED

Safety and/or risk issues

We ask the following questions to determine if there are any safety or risk issues of which we should be aware. Answering any of the questions below *will not* exclude the applicant from service. Please include when, how many incidents, how severe and the outcome.

Known history of violence: ☐ Yes ☐ No

Level of risk: ☐ low ☐ moderate ☐ high

Present risk factors (check all that apply):

☐ Suicidal ideation
☐ Self-injurious behaviours
☐ Thought to harm others
☐ Plan to harm other
☐ Aggressive/violent behaviour
☐ Suicidal attempt(s)
☐ Delusions or hallucinations
☐ Addiction concerns/overdosing history
☐ Housing stability

Behaviour and risk(s)

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

☐ Uncooperative ☐ Threats ☐ Verbal abuse ☐ Hostile/attacking ☐ Assaultive/combative

☐ No aggressive behaviour exhibited

Known risk factors/triggers:

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

- Mitigation strategies for known risk factors/triggers: ☐ Yes ☐ No _____
- History of self-harm or suicide threats or attempts: ☐ Yes ☐ No _____
- History of substance use or treatment: ☐ Yes ☐ No _____
- History of aggression behavior or violence (verbal, physical, sexual): ☐ Yes ☐ No _____
- History of destruction of property: ☐ Yes ☐ No _____
- History of any other risk or safety issue: ☐ Yes ☐ No _____

If yes to any of the above, please describe:

_____

_____

Is the applicant currently or has been involved In the past with the criminal justice system? ☐ Yes ☐ No

Please note, that this will *not* affect their ability to receive service. It is to help us better direct the application.

If yes, please indicate types of involvement (check all that apply), dates and outcomes:

☐ Bail order ☐ Parole ☐ Probation ☐ Incarcerations ☐ Not criminally responsible (NCR)

☐ Restraining order

Date(s): _____

Outcome(s): _____

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VIOLENCE/AGGRESSION ASSESSMENT CHECKLIST (VAAC) — REQUIRED

Existing supports

Is the applicant currently working with any other service providers? ☐ Yes ☐ No

If YES, please provide the following information on each service provider with whom:

NAME OF AGENCY	NAME OF CONTACT	SERVICE(S) RECEIVED	TELEPHONE

Notes:

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SUPPORTING DOCUMENTATION, DECLARATIONS AND CONSENTS

Supporting documentation

In order for us to process this referral, it is essential that we receive as much of the following documentation as is available to you:

- ☐ Hospital discharge summaries (complete hospital documentation, within the last two years)
- ☐ Psychiatric hospitalization(s)
- ☐ Specialty and/or specialist Aassessments
- ☐ Comprehensive assessments (e.g., psychosocial histories, addiction assessments and occupational therapy (OT) assessments
- ☐ Community Treatment Orders (CTOs)
- ☐ Form 33 — Notice to Patient
- ☐ Completed Intake Criteria Screening Tool

Applicant's and referrer's declaration and consent

Consent form allowing communication between the referral source and the OTTAWA ACTT Central Intake Team has been included. ☐ Yes ☐ No

I have discussed this referral with the applicant and the applicant agrees with the submission of this referral.

☐ Yes ☐ No

REFERRER

Signature: _____ Date: _____ DD/MM/YYYY

APPLICANT

Signature: _____ Date: _____ DD/MM/YYYY

Applicant's verbal consent (indicated by checking this box): ☐

SUBSTITUTE DECISION MAKER

Signature: _____ Date: _____ DD/MM/YYYY