REFERRAL FORM (LONDON)

All Referrals for LONDON WOTCH PROGRAMS will be processed through Centralized Intake. This form, as well as the CDS-MH and a signed consent for release/exchange of information must be completed for all referrals. Individuals/Agencies trained and licensed to use the Camberwell are requested to submit a completed Camberwell with the Referral Package.

For additional referral information phone 519-668-0624 or visit our website at www.wotch.org
(For services in Huron County contact the WOTCH North Offices in either Exeter at 519-235-0335 or Goderich at 519-440-0450)

CLIENT NAME: ______________________________

D.O.B. (mm/dd//yyyy): ______________________________

Please check all services for which your client is referred:

☐ **WOTCH Intensive Case Management**

Services are voluntary and provided within a framework of psychosocial rehabilitation and recovery. Each client referred for intensive case management services will have a Case Manager (CM) assigned. Together with the client, the CM assists in developing and implementing an individualized rehabilitation plan to meet the client's needs

☐ **Community Programs:** ***(Check all that are applicable)***

☐ **Life Management Program**

The focus of this group is for clients who want to develop and/or strengthen relevant life skills. Led by a multi-disciplinary team, participants complete units in three primary areas: goal-setting, health and wellness management, and community living skills

☐ **Community Integration**

Reconnecting with the community, regaining self-confidence, restoring self-esteem and achieving recovery goals is promoted through involvement in a variety of structured leisure and life skills-focused groups and activities

☐ **Vocational Rehabilitation Services**

Individuals' vocational goals are supported through one-on-one consultations, vocational assessments, skills training, job preparation, transitional work placements and assistance with obtaining and maintaining competitive employment. Social and economic independence is promoted

Continued on next page

☐ **Treatment Services** ***(Check all that are applicable)***

☐ **Residential Treatment Facility**

Short-term residential treatment facility that offers 24-hour per day support with clinical support from nursing staff for people with a serious mental illness who need an alternative to hospitalization. The housing provides an environment in which individuals are exposed to typical community settings and expectations

☐ **Rehab Housing group homes**

Short-term residential environment to learn and strengthen interpersonal skills and enable the pursuit of individual goals. Less intensive than the Residential Treatment Facility with flexible staff providing varying levels of support for individuals who might otherwise need a more structured program

☐ **Permanent Housing:** ***(Check all that are applicable)***

☐ **Shared living**

Living independently in the community in a shared home with two or three co-tenants

☐ **Independent Apartment**

Living independently in one's own apartment, subject to a waitlist

Please FAX completed package/checklist to WOTCH at 519 668 3641

REFERRAL FORM
(LONDON)

REFERRAL SOURCE ____**External** ____**Self**

Referred by (please print name): ______________________ Date of Referral: ____________
mm / dd / yyyy

Agency/Area: ______________________ Phone & ext.: ______________________

Fax: ______________________ Email address: ______________________

CLIENT INFORMATION

Name of Client (please print): ______________________

D.O.B.: ______________ Gender: __________ Marital Status: ______________

Address: ______________________

City: ______________ Postal Code: __________ Phone: ______________

Health Card Number: ______________________

Income Source: ______________________

Highest level of education completed: ______________________

Okay to leave message? ☐ **yes** ☐ **no**

KEY SUPPORTS (*Consents required for contact*)

Name of emergency contact person: ______________________

Address: ______________________ Phone: ______________

Relationship to client: ______________________

Next of Kin (if different from emergency contact): ______________________

Address: ______________________

City: ______________ Postal Code: __________ Phone: ______________

DIVERSITY / LANGUAGE / CULTURE

Aboriginal: ☐ yes ☐ no

Culture and Preferred Language: ______________________

Citizenship/Current Immigration Status: ______________________

Spiritual / Cultural Beliefs: : ______________________

____

CLIENT NAME:	DATE OF BIRTH:

HEALTH

		Confirmed By	Date
Axis I Diagnosis			
Axis II Diagnosis			
Axis III Diagnosis			
Allergies			
Physical Disability			

Smoker: ☐ yes ☐ no

Medications	Dose	Frequency

Please attach an additional sheet if more space is needed to complete Medications portion.

Is client currently in hospital: ☐ yes ☐ no Date of Admission: ____________________

Most recent hospitalization: ____________________ Length of Stay: ____________________

Hospital Name____________________ Number of Hospitalizations in last 2 years: ____________

HEALTH SYSTEM SUPPORTS

Psychiatrist: ____________________ Phone:____________________

Address:____

Family Physician: ____________________ Phone: ____________________

Address:____

Other:____

____

____

Has the client been involved with Mental Health Crisis Service/WOTCH/CMHA in past: ☐ yes ☐ no

Details of involvement: ____

____

CLIENT NAME: DATE OF BIRTH:

ASSESSMENT INFORMATION *(please attach copies)*

Camberwell ☐ Psychiatric assessment ☐ Psychosocial assessment ☐ OT assessment ☐

Other *(Specify)*:

RISK FACTORS *(If "**Yes**" please provide date and details)*

Abuses alcohol or drugs(non-prescription or prescription) ☐ yes ☐ no ☐ Unknown

Details of substance misuse ______________________________

____

Receives treatment for drugs or alcohol? ☐ yes ☐ no ☐ Unknown

Details of treatment *(Include dates(s))*:______________________________

____

Recent or past involvement with Police? ☐ yes ☐ no ☐ Unknown

Details of Police Involvement (*Include date(s)):*______________________________

____

Currently on Probation/Parole? ☐ yes ☐ no ☐ Unknown

Details of Probation/Parole (*Include date*):______________________________

____

Self Abuse? ☐ yes ☐ no ☐ Unknown

Details of Self Abuse (*Include date(s*)):______________________________

____

Physical Abuse/Aggression to Others? ☐ yes ☐ no ☐ Unknown

Details of abuse/aggression (*Include date(s*)):______________________________

____

Has client damaged property? ☐ yes ☐ no ☐ Unknown

Details of Property Damage (*Include date(s)):* ______________________________

____

Suicide Attempts? ☐ yes ☐ no ☐ Unknown

Details of Suicide Attempts *(Include date(s)):*______________________________

____

Communicable Diseases? ☐ yes ☐ no ☐ Unknown

Details of communicable disease *(Include date(s*)):______________________________

____

CLIENT NAME: DATE OF BIRTH:

Currently describes self in crisis? ☐ yes ☐ no ☐ Unknown

Details of current crisis:____

If available, please attach a copy of the client's crisis plan.

Does the client live with an abusive partner, roommate or family member?

☐ yes ☐ no ☐ Unknown

If *yes*, please provide details:____

Does the client have pets in the home? ☐ yes ☐ no ☐ Unknown

If *yes*, please specify:____

Are there any other known or potential risk factors not identified above?

☐ yes ☐ no ☐ Unknown

If *yes*, please provide details:____

Is there any other information that might be useful: ____

For what issues is the client being referred for community mental health services?

☐ Mental Health Symptoms	☐ ADL's	☐ Housing
☐ Addictions	☐ Financial	☐ Employment/Education
☐ Physical Health	☐ Relationships	☐ Leisure/Recreation
☐ Legal	☐ Other:____________________	

CONSENT FOR RELEASE OF PERSONAL INFORMATION

I, ______________________________ ________/______/______
(Print person's full name and date of birth) month day year

hereby give my consent to allow

WOTCH Community Mental Health Services

and

____
(Print name of agency or individual)

to share information for the purpose of providing services

______________________________ ________/______/______
Signature Month Day Year

______________________________ ________/______/______
Witness Month Day Year

Expiry date: ________/____/______ **Ongoing:** ______________
Month Day Year Initials of person giving consent

I understand that I can withdraw my consent at any time by providing written notice for withdrawal of consent. I understand that no information will be released to other parties without my consent unless there is a legal requirement to do so or a serious concern about my safety or the safety of others.