

**ACTT Program Referral Form**  
**Mount Sinai Hospital**  
**Community Mental Health Program**  
**Assertive Community Treatment Team (ACTT)**

In joint venture with Hong Fook Mental Health Association  
 Suite 204, 260 Spadina Avenue, Toronto, ON M5T 2E4  
 Phone: 416-586-9900 Fax: 416-586-9700  
 Revision 2.1 (1) 2001.07.20

(please print)

**Date of Referral:** \_\_\_\_\_

**Name of referring psychiatrist / therapist / case manager:** \_\_\_\_\_

**Primary Referring hospital / agency:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Fax Number:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Chart Number: (if applicable)** \_\_\_\_\_

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

**Phone # 1:** \_\_\_\_\_ **Phone # 2:** \_\_\_\_\_

**Date of Birth: (dd/mm/year)** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Gender** \_\_\_\_\_

**Age of onset** \_\_\_\_\_

**SIN Number:** \_\_\_\_\_ **Health Card #:** \_\_\_\_\_

**Ethnic Identity (How client sees self):** \_\_\_\_\_

**If not born in Canada: Country of Origin** \_\_\_\_\_ **Years in Canada** \_\_\_\_\_

**Preferred Language:** 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**Language :** **Spoken:** \_\_\_\_\_ **Read:** \_\_\_\_\_ **Written:** \_\_\_\_\_

**Ability to Communicate in English:** **Fluent**  **Adequate**  **Limited**

**Please indicate other significant supports:** **Current** **Previous**

<b>Hong Fook Mental Health Association</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Centre for Addiction and Mental Health</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>St. Joseph's Health Centre</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>St. Michael's Hospital</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Sunnybrook</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Toronto Hospital</b>	<input type="checkbox"/>	<input type="checkbox"/>

- |   |                          |                          |
|---|--------------------------|--------------------------|
| <b>Toronto East General Hospital</b>        | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Trillium</b>                             | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>William Osler Health Centre</b>          | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>COTA</b>                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>CRCT</b>                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Regeneration House</b>                   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Madison Housing and Support Services</b> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Homecare</b>                             | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Other</b>                                |                          | <b>Please Specify:</b>   |

\_\_\_\_\_

**1. Reason(s) for referral – check those that are applicable:**

- \_\_\_\_\_ 1) Has been assessed to be at risk of requiring a more restrictive living situation such as a group home or psychiatric hospital unless more intensive services are received;
- \_\_\_\_\_ 2) For the last six months has been a resident of a inpatient facility, (e.g. Hospitals, CAMH) but has been clinically assessed to be ready to move to a more independent living situation provided that intensive supportive services are available;
- \_\_\_\_\_ 3) Currently does not receive mental health services and has refused attempts to provide services for at least the last six months and has been assessed to be at risk without mental health treatment and support;
- \_\_\_\_\_ 4) Has a primary major mental illness but also is involved with the criminal justice / legal system with a least one arrest or conviction on misdemeanor or felony charges during the last six months and is judged to be in need of more intensive supportive services;
- \_\_\_\_\_ 5) Has a primary major mental illness but also co-morbid substance abuse disorder that has persisted for at least the last six months and is judged to benefit from more intensive supportive

**2. DSM-IV Diagnosis**

Axis I	Axis II	Axis III	Axis IV

Axis V \_\_\_\_\_

**3. Prescribed medications for the treatment of psychiatric conditions**

Type of Medications	Dose / Frequency	Started When?
1.		
2.		
3.		
4.		
5.		

**Pharmacy Name:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**4. Psychiatric Hospitalizations for the last 5 years:**

Number of admissions: \_\_\_\_\_

Location of hospitalizations:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

Date / location of last admission: \_\_\_\_\_

Previous suicide attempt (s)                      Yes                       No

Pervious violence toward others:                      Yes                       No

**5. Legal involvement**

• Current legal involvement                      Yes                       No

• Past legal involvement                      Yes                       No

If yes to either, please complete the following:

Date	Charge	Status	Restriction as a result of legal involvement

**6. Current medical problems which require treatments by a physician:**

Treatment provider (physician's name)	Address & phone number	Medical problem (s)

**7. Substance abuse / Illegal drug abuse:**

(Include alcohol, caffeine, nicotine, OTC drugs, street drugs)

Type of drugs	Amount / Frequency	Treatment HX / Additional information *

\* Specify past or current – inpatient or outpatient – AA meetings – Double Trouble Group etc.

**8. Family / Significant others:**

Name (s)	Relationship	Address & Phone

**9. Finances**

Does client have a public trustee?      Yes \_\_\_\_ No \_\_\_\_ if so Who? \_\_\_\_\_

Is money budgeted by anyone?      Yes \_\_\_\_ No \_\_\_\_ if so Who? \_\_\_\_\_

Position: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**10. Income / Assets: (Does client have or receive following)**

	Yes	No	Amount		Yes	No	Amount
1. ODSP	<input type="checkbox"/>	<input type="checkbox"/>	_____	2. Welfare	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. EI	<input type="checkbox"/>	<input type="checkbox"/>	_____	4. DP	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Income From Family	<input type="checkbox"/>	<input type="checkbox"/>	_____	6. Savings	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Others	<input type="checkbox"/>	<input type="checkbox"/>	_____				

**11. Patient current living status:**

hospital inpatient       supportive housing       living with relatives   
 living alone       homeless       other  (please specify) \_\_\_\_\_

**12. Housing (if applicable):**

Monthly rental cost \_\_\_\_\_ Monthly payment due date: \_\_\_\_\_

Landlord's name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Describe housing (check applicable descriptions)

- |                                   |                                   |                                       |                                    |
|-----------------------------------|-----------------------------------|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Stable   | <input type="checkbox"/> Safe     | <input type="checkbox"/> Affordable   | <input type="checkbox"/> Organized |
| <input type="checkbox"/> Unstable | <input type="checkbox"/> Not Safe | <input type="checkbox"/> Unaffordable | <input type="checkbox"/> Chaotic   |

## Referral Summary

### 1. Diagnosis

- Severe and persistent mental illness such as schizophrenia or bipolar disorder  
Yes  No
- Concurrent disorder  
Yes  No

### 2. Duration

- Ten year psychiatric history  
Yes  No
- Five or more admission for the past 5 years  
Yes  No
- **TOTAL LENGTH** of inpatient admissions for the past 5 years
  - < 2 months
  - 2-6 months
  - 6 months to 1 year
  - 1 year to 3 years
  - 3 years to 5 years

### 3. Clinical follow-up

Needs monthly contact	needs contact every 2-weeks	needs contact every week	needs daily contact
1	2	3	4

### 4. Disability

- Activities of daily living (personal hygiene, dressing appropriately, meeting nutritional needs, avoiding danger/risk)

independent	needs occasional reminders	needs frequent reminders/supervision	unable to manage without constant supervision
1	2	3	4

- Housing

independent	assisted supportive housing, staff on-call and /or periodic visits	supervised, secondary responsibilities, continuous supervision	high support, staff on-site and available at all times
1	2	3	4

- Finances

needs assistance with bills, but able to manage remaining funds	needs assistance with bills and requires weekly allowance	needs assistance with bills and requires a daily allowance	is unable to manage funds at all
1	2	3	4

- Program/Employment/Education (utilization of day care, workshops, employment, education and other resources)

independent	independent when provided with information	requires information, encouragement and reminders	requires the accompaniment of a worker
1	2	3	4

- Medication compliance

independent	independent with prompts e.g. phone-calls	will comply, but requires encouragement and followup	requires daily dispensing and monitoring of medications
1	2	3	4

- Social support

established/reliable social network accessed by client independently	expresses some dissatisfaction with current social network and actively seeks improvement	has some social contacts but requires encouragement to improve social network	regularly requires direction/encouragement to engage with others
1	2	3	4

- Recreation / Leisure

independent	independent when provided with information	requires information, encouragement, and reminders	requires the accompaniment of a worker
1	2	3	4

- Transportation

independent	needs verbal directions	needs to be accompanied	can not use
1	2	3	4

**Additional Comments:**

---



---



---



---



---



---



---



---



---



---

**Thank you for taking the time to fill out this form**