Attachment "A"
Authorization for Release of Information
ACT (Assertive Community Treatment)
Referral Process

Please Complete Section 1 and 2

Section 1

A Community Intake Group assists the ACT Teams in Waterloo Region by reviewing new referrals. This group helps ensure that those people whom most need ACT services in the region receive them. The Community Intake Group is comprised of:

- Cambridge Memorial Hospital
- Canadian Mental Health Association – Grand River Branch
- Community Care Access Centre – Waterloo Region
- Grand River Hospital
- Waterloo Region Homes for Mental Health
- St. Joseph's Health Care London - Waterloo Region ACT & Transition Teams

Please check off either 1.1 or 1.2

1.1 ( ) The attached Authorization for Release of Information allows information from the referral to ACT to be shared with the Community Intake Group; in order for this group to assist with intake.

OR

1.2 ( ) The attached Authorization for Release of Information allows for non-identifying information from the referral to ACT to be shared with the Community Intake Group; in order for that group to assist with intake.

Section 2

The attached Authorization for Release of Information will be used for the next 6 months, expiring on_____ unless otherwise revoked.

_____ _____

Witness Signature

Date_____

day/month/year

ACT TEAM REFERRAL FORM FOR WATERLOO REGION
c/o Unit 109 - 725 Coronation Boulevard, Cambridge, Ontario N1R 7S9
Phone: 519-621-2828 Fax: 519-621-4904

Each referral will be assessed in order to determine if ACTT is the appropriate level of support required. Please complete all information; incomplete referrals cannot be processed.

APPLICANT INFORMATION

Date of Referral: _____
Month day year

Name _____ Address _____
First Middle Surname Street Apt/Unit

City _____ Postal Code _____ Telephone _____ Other _____
(Area Code)

DOB ____/____/____ Age____ Male □ Female □ Ontario Health Card # _____
M D Y

Ontario Health Card Version Code _____

Current Status: □ Inpatient-Voluntary □ Inpatient Involuntary □ Outpatient □ Client of Community Program

Preferred Language: □ English □ French □ Other - specify _____

Emergency Contact: _____ Telephone: _____
(Area Code)

_____

_____

INTAKE INFORMATION

DSM IV Diagnosis: _____

Comorbid Diagnosis: _____

Functional Impairments: _____

Acceptance Criteria

Hospitalizations:

# of admissions to Schedule 1 Psych. Units _____

# of admissions to Prov. Psych. Hospital _____

# of days in hospital in last 12 mths _____ 24 mths _____

# of ER visits in the last 12 mths _____ 24 mths _____

Last Discharge: _____ Location: _____

Substitute Decision Maker Yes □ No □ Contact Information:

_____

Financial Incapacity Yes □ No □ Contact Information:

_____

Major Psych. Symptoms considered intractable	Yes □	No □
Criminal Justice Involvement	Yes □	No □
Co-existing substance use disorder	Yes □	No □
Homelessness or risk of homelessness	Yes □	No □
Assessed as able to live more independently	Yes □	No □
Able to attend traditional Outpatient Services	Yes □	No □
Waterloo Region is the county of origin or residence	Yes □	No □
Community Treatment Order	Yes □	No □

Renewal Date: _____

ADDITIONAL INFORMATION TO AID COMMUNITY INTAKE GROUP

History of Psychiatric Involvement:

_____

_____

_____

History of Previous Agency Involvement:

_____

_____

_____

Present Agency Involvement (amount of time spent, support need, barriers preventing recovery plan from working):

_____

_____

_____

Medication – Management/Compliance:

_____

_____

_____

Family/Caregiver Stress:

_____

_____

_____

Psychosocial Area (interpersonal conflicts; family contact, bio-cultural):

_____

_____

_____

Criminal History:

_____

_____

_____

Health & Safety Issues (violence to self or others, sexually inappropriate behaviour, housing, dogs, communicable diseases):

_____

_____

_____

Effect of Comorbid Conditions:

_____

_____

_____

List of Current Strengths/Resources (check all that apply):

Economic Resources
□ Employment □ Transportation □ Financial
□ Housing □ ODSP/CPP

Education/Skill Resource
□ Language/Skills □ Intelligence □ Job Skills
□ Education □ Interpersonal Skills

Person Resources
□ Parent(s) □ Partner □ Professional Caregiver
□ Sibling(s) □ Child(ren) □ Relative(s)
□ Friend(s) □ Other Supportive Relationship
□ General Practitioner □ Crisis Plan

Personal Strengths
□ Likeableness □ Emotional Stability □ Adaptability
□ Appearance □ Health □ Thought Clarity
□ Confidence □ Hopefulness □ Resourcefulness
□ Judgment □ Responsibility □ Tolerance
□ Empathy □ Insight

COLLATERAL CONTACTS

Attending Psychiatrist _____ Frequency Seen _____

Attending Physician _____ Last Seen _____

Present Involvement with other community or outpatient programs: Yes □ No □

Program _____ Primary Worker _____

Program _____ Primary Worker _____

Program _____ Primary Worker _____

Are the collateral contacts in support of the Referral to ACTT? Yes □ No □

REFERRAL SOURCE

Name of Referral Agency (please print) _____

Referral Contact Name _____

Address _____ Telephone # _____ Fax # _____
(include area codes)

Signature of Referral Source _____

Please Note: Referral Package includes Consent Form and Camberwell CANSAS document. Please complete all. If you have any questions, please contact Waterloo Region ACTT at 519-621-2828 or Waterloo Regional Homes for Mental Health ACTT at 519-742-3191 Ext. 223.

CANSAS

CAMBERWELL Assessment of Need Short Appraisal Schedule

Domain	Need Rating 0 = no problem 2 = unmet need 1 = met need 9 = unknown	
	Rating	**Comment** (optional)
1. Accommodation		
2. Food		
3. Looking after home		
4. Self-care		
5. Daytime activities		
6. Physical health		
7. Psychotic Symptoms		
8. Information		
9. Psychological distress		
10. Safety to self		
11. Safety to others		
12. Alcohol		
13. Drugs		
14. Company		
15. Intimate Relationships		
16. Sexual expression		
17. Child care		
18. Education		
19. Telephone		
20. Transport		
21. Money		
22. Benefits		
Number of met needs (Number of 1's)		
Number of unmet needs (Number of 2's**)**		
Total number of needs (Number of 1's and 2's)		

***Camberwell Assessment of Need Short Appraisal Schedule courtesy of King's College, London**

AUTHORIZATION FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE

- ☐ St. Joseph's Health Care & Waterloo Regional Homes for Mental Health Community Intake Group

TO RELEASE THE FOLLOWING INFORMATION: (Please describe)

_____

CONCERNING TREATMENT ON: (Date of visits/contacts/hospitalization)

_____

FROM THE HEALTH RECORD OF:

Patient/Client Name: _____ Date of Birth:_____
Last Name Given Name Middle Name (YYYY/MM/DD)

Address: _____

_____ Telephone #:_____

Person/Agency to receive information:_____

Address:_____ Telephone #: _____

I understand that this information is to be used by the Recipient for the purpose of ACT Team Referral to a team in Waterloo Region – see Appendix A.

Individual (with legal signing authority) requesting Health Record:

Printed Name:_____ Signature:_____

Relationship if other than patient/client: (Patient/client is under 16, incapable, or deceased)

_____

Address & Telephone # if different from above:

_____

Witness: _____

Printed Name: _____ Signature: _____

Date: _____
(YYYY/MM/DD)

_____

Please Note: This Authorization for Release of Health Records is valid for 6 months and pertains to the disclosure of information that is specific to treatment received on or before the date signed. It can be amended or withdrawn at any time by written notification to the hospital.