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
- Thresholds Homes and Supports
- 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: ___________________________ ________________

Name ___________________________ Address ___________________________

First Middle Surname Street Apt/Unit

City __________________ Postal Code __________ Telephone (Area Code) Other __________

DOB __________ __________ __________ Age Male □ Female □

Ontario Health Card # __________________________

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):

<table>
<thead>
<tr>
<th>Economic Resources</th>
<th>Education/Skill Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Language/Skills</td>
</tr>
<tr>
<td>Transportation</td>
<td>Intelligence</td>
</tr>
<tr>
<td>Financial</td>
<td>Job Skills</td>
</tr>
<tr>
<td>Housing</td>
<td>Education</td>
</tr>
<tr>
<td>ODSP/CPP</td>
<td>Interpersonal Skills</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Person Resources</th>
<th>Personal Strengths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent(s)</td>
<td>Likeableness</td>
</tr>
<tr>
<td>Partner</td>
<td>Emotional Stability</td>
</tr>
<tr>
<td>Professional Caregiver</td>
<td>Adaptability</td>
</tr>
<tr>
<td>Sibling(s)</td>
<td>Appearance</td>
</tr>
<tr>
<td>Child(ren)</td>
<td>Health</td>
</tr>
<tr>
<td>Relative(s)</td>
<td>Thought Clarity</td>
</tr>
<tr>
<td>Friend(s)</td>
<td>Confidence</td>
</tr>
<tr>
<td>Other Supportive Relationship</td>
<td>Hopefulness</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>Resourcefulness</td>
</tr>
<tr>
<td>Crisis Plan</td>
<td></td>
</tr>
</tbody>
</table>

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 # __________

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 Thresholds Homes and Supports ACTT at 519-742-3191 Ext. 223.
CANSAS

*CAMBERWELL Assessment of Need Short Appraisal Schedule*

<table>
<thead>
<tr>
<th>Domain</th>
<th>Need Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 = no problem</td>
</tr>
<tr>
<td></td>
<td>Rating</td>
</tr>
<tr>
<td>1. Accommodation</td>
<td></td>
</tr>
<tr>
<td>2. Food</td>
<td></td>
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<tr>
<td>3. Looking after home</td>
<td></td>
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<td>4. Self-care</td>
<td></td>
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<tr>
<td>5. Daytime activities</td>
<td></td>
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<tr>
<td>6. Physical health</td>
<td></td>
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<tr>
<td>7. Psychotic Symptoms</td>
<td></td>
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<tr>
<td>8. Information</td>
<td></td>
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<tr>
<td>9. Psychological distress</td>
<td></td>
</tr>
<tr>
<td>10. Safety to self</td>
<td></td>
</tr>
<tr>
<td>11. Safety to others</td>
<td></td>
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<tr>
<td>12. Alcohol</td>
<td></td>
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<tr>
<td>13. Drugs</td>
<td></td>
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<td>14. Company</td>
<td></td>
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<td>15. Intimate Relationships</td>
<td></td>
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<td>16. Sexual expression</td>
<td></td>
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<td>17. Child care</td>
<td></td>
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<td>18. Education</td>
<td></td>
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<tr>
<td>19. Telephone</td>
<td></td>
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<tr>
<td>20. Transport</td>
<td></td>
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<tr>
<td>21. Money</td>
<td></td>
</tr>
<tr>
<td>22. Benefits</td>
<td></td>
</tr>
</tbody>
</table>

| 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 & Thresholds Homes and Supports Inc. 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: ____________________________ (YYYY/MM/DD)

Last Name: _______________________ Given Name: _______________________ Middle Name: _______________________

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: ____________________________

Relation 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.