Intensive Case Management Access Coordination (IntĀc)
Service Request Form

please COMPLETE FORM and fax to 1-866-845-2019; or mail to IntĀc, 131 John St. S., Hamilton, ON, L8N 2C3

NOTE: Street Outreach referrals can be made by:
(a) faxing *page one only* of this form, or (b) calling IntĀc: ***905-528-0683***

***** = must complete***

Requested Service ☐ Street Outreach (client is homeless) ☐ Intensive Case Management

Date of Referral:**

Please answer the following questions.

1. Is the person you are referring 16 years of age or over? ☐ Yes ☐ No
2. Does the person have a family physician? ☐ Yes ☐ No
3. Is the person permanently housed in Hamilton? ☐ Yes ☐ No
4. Does the person have a mental health diagnosis? ☐ Yes ☐ No

If you have answered "Yes" to all of the questions above, please continue to provide all information in this Referral Form.

If you have answered "No" to any of the questions above, please contact the Canadian Mental Health Association, Hamilton Branch at (905) 521-0090 or info@cmhahamilton.

Client Information

Name:** | DOB: *(YYYY MM DD)* | Age: | Gender:** | Marital Status: | ☐ Aboriginal ☐ Non-Aboriginal

Health Card #: | VC:

Does person requesting service require accommodation?** ☐ Yes ☐ No
If "Yes", explain:

Address / Emergency Shelter / Last Location Seen:**

Physical Description of Client:** *for Street Outreach Only*

Phone #:** *if available*

Can client speak/understand English?** ☐ Yes ☐ No
Preferred Language:

Emergency Contact Information:** *if available*

Employment (current status):

Highest level of education:

Do staff need to be aware of any past or current safety issues (self or others)?** *If yes, explain:* ☐ Yes ☐ No

Referral Source

Self Referral?** ☐ Yes ☐ No

Name: **

Position / Title:

Agency Name:** *if applicable*

Phone:** *if applicable* | Ext.: | Fax:

Referral Source (role, frequency of interaction, length of time involved, and client's response to treatment):** *if applicable*

If a physician is providing the referral, please provide the following information:

Referring Physician name (please print) | Referring Physician Signature | OHIP Billing #

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Family Physician / Nurse Practioner	**Psychiatrist**
Name:	Name:
Phone:	Phone:
Fax:	Fax:
Office Address:	Office Address:
Is family physician aware of referral? ☐ Yes ☐ No	Is psychiatrist aware of referral? ☐ Yes ☐ No

Has the client provided verbal permission to contact his/her healthcare providers? ☐ Yes ☐ No ☐ N/A

Current Supports / Contacts ***(professional, family, friends, peers, etc.; Please indicate if Substitute Decision Maker)***

Name:	Relationship:	Phone:

Specialists or Other Agencies Involved ***(include past supports)***

Current or past services involved:	Details: (e.g. agency, contact, date of service)
☐ counselling services	
☐ vocational services	
☐ addiction services	
☐ mental health services / treatment	
☐ Children's Aid Society	
☐ housing program	
☐ other ***(specify)***	

Are referrals also being provided to other agencies or services? (If "Yes" please specify)

Mental Health:

Diagnoses:

Reason(s) for referral to Intensive Case Management services.
(ie. how does the mental health of the person being referred affect their ability to live well?)

Current and Past Psychiatric History ***(please check and make comments where relevant)***

☐ Suicide History

☐ Aggressive Behaviour

☐ Substance Use / Addictions

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☐ Hospitalization History

☐ Community Treatment Order (if "Yes" please provide documentation)

☐ Vulnerability to Risk / Exploitation

Current and Past Medical History

Medical Diagnoses:

Acquired Brain Injury / Traumatic Brain Injury ☐ Yes ☐ No (If "Yes" please indicate impact on functioning)

Developmental Disability (If "Yes" please indicate i ☐ Yes ☐ No (If "Yes" please indicate impact on functioning)

Current Medications ***(if more space required, please attach list)*** **Document Allergies**

Current and Past Legal History

Current involvement with probation/parole? ☐ Yes ☐ No (If "Yes" please indicate name of probation/parole officer)

Previous involvement with probation/parole? ☐ Yes ☐ No

Ontario Review Board ☐ Yes ☐ No (If "Yes", please provide documentation)

Do staff need to be aware of any past or current safety or behavioural issues when approaching the person being referred?** ☐ Yes ☐ No ***If yes, explain:***

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Rehabilitation Goals

Goals identified by client:

Comments

Please provide any other relevant information as needed: