HOME AND COMMUNITY CARE SUPPORT SERVICES
Waterloo Wellington

MENTAL HEALTH & ADDICTIONS REFERRAL FORM

Legal name (on HCN): _____ Preferred Name: _____

Gender: ☐ Male ☐ Female ☐ Identify as Other ☐ Non- Binary Pronouns used: _____

Do you self-identify as having First Nations (status or non-status), Métis, or Inuit ancestry?: ☐ Yes ☐ No

Home Address: _____

City: _____ Postal Code: _____

Phone: _____ Cell Phone: _____

HCN: _____ VC: _____ DOB (dd/mm/yy): _____

Family Physician: _____ Out-patient Psychiatrist: _____

☐ Student is in the Care of Children's Aid Society (Child's Aid Society is student's legal guardian)

Protection Agency and Worker: _____ Contact: _____

Parent, Guardian or Other Contact Information

☐ Mother ☐ Father ☐ Other ☐ Emergency Contact	☐ Mother ☐ Father ☐ Other ☐ Emergency Contact
☐ Share PHI ☐ Share NO PHI	☐ Share PHI ☐ Share NO PHI
Name: _____	Name: _____
Home phone: _____	Home phone: _____
Cell phone: _____	Cell phone: _____
Address: _____	Address: _____
City: _____ Postal Code _____	City: _____Postal Code _____

Languages Spoken in Home ☐ English ☐ French ☐ Other Specify_____

Interpreter Required ☐ No ☐ Yes Specify _____

Consent for Referral to MHAN program

☐ I give permission to the MHAN program to collect information for the purpose of providing care/services, to share that information with those in the circle of care and to notify/speak to my school: _____ that I am participating in the MHAN program. No other info will be shared with my school or others without my informed consent.

Verbal Consent obtained from: ☐ Student ☐ Parent Date:_____

Health Information

☐ MH Concerns: _____

☐ Allergies: _____

☐ Community Agencies Involved with Student: _____

Risk Factors

☐ Suicidal Ideation/attempts ☐ Passive ☐ Active Specify: _____

☐ Safety Concerns in home Specify: (fire arms, weapons, pets, smoking): _____

☐ Relevant Family history/stressors specify: _____

☐ Nicotine/Vaping ☐ Alcohol ☐ Addiction concerns ☐ Drugs specify: _____

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Mental Health Nursing Role Needs of Student

☐ Medication Concerns/side effects ☐ Medication changes ☐ Medication Education

Please list current medications: _____

☐ Transition from Hospital Specify: _____

☐ MH Health System Navigation Specify: _____

☐ Health Teaching (Nutrition, Physical Activity etc.) ☐ Sleep hygiene ☐ Other: _____

Patient History/Pertinent Information

CLINICAL referral source to complete: ☐ Inpatient Hospital: _____ Discharge Date: _____

☐ ER: _____ ☐ Outpatient Clinic: _____ ☐ Pediatrician ☐ Psychiatrist ☐ Family Physician

MRP Name: _____ Signature: _____ Date: _____

☐ Community Partner/other: _____

Contact Name: _____ Position: _____ Phone: _____

***Please attach any relevant Medical History, Medication list and Collateral information to fax number provided on form.**

SCHOOL referral source to complete:

☐ Upper Grand District School Board ☐ Wellington Catholic District School Board

**Upper Grand and Wellington referrals can only be made by psychology department, SW and CYW

☐ Waterloo Region District School Board ☐ Waterloo Catholic District School Board

**Waterloo Region and Waterloo Catholic referrals can only be made by or signed off by psychology dept. or SW

☐ Private School/Other: _____

School Contact Name: _____ Position: _____ Phone: _____

HCCSS Child and Youth Mental Health & Addictions Fax: 1 (519) 571-3957

A MH nurse will connect with student, parent and/or guardian to confirm consent and determine eligibility.