HOME AND COMMUNITY CARE SUPPORT SERVICES
Waterloo Wellington

MENTAL HEALTH AND ADDICTIONS NURSING PROGRAM (MHAN)

FAX: (519) 571-3957

Legal name on Health Card (HCN): ____________________ Preferred Name: ____________________

HCN: ____________________ VC: __________ DOB (dd/mm/yyyy): ____________________

Gender: ☐ Male ☐ Female Gender Identity: ____________________ Pronouns used: ____________________

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

Preferred language: ☐ English ☐ French Other: ____________________ Interpreter Required Yes ☐ No ☐

Home Address: ____________________ City: ____________________ Postal Code: ____________________

Home Phone: ____________________ Student's Cell: ____________________

Family Doctor: ____________________ Psychiatrist: ____________________

☐ Community Agencies involved: ____________________

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

Protection Agency and Worker: ____________________ Contact: ____________________

Contact Information

☐ Mother ☐ Father ☐ Guardian ***Ok to contact** Yes ☐ No ☐

Name: ____________________

Home phone: ____________________ Cell: ____________________

Address: ____________________

City: ____________________ Postal Code ____________________

☐ Mother ☐ Father ☐ Guardian ***Ok to contact** Yes ☐ No ☐

Name: ____________________

Home phone: ____________________ Cell: ____________________

Address: ____________________

City: ____________________ Postal Code ____________________

Consent for Referral to Child/Youth MH (MHAN) program

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

School enrolled: ____________________ City: ____________________ Ph: ____________________

Health Information

☐ Presenting MH Concerns: ____________________

Medication List: ____________________ ☐ Attached Medical List

☐ Allergies: ____________________ ☐ Suicidal Ideation/attempts ☐ Passive ☐ Active ☐ Historical

☐ Relevant Family MH history/stressors specify: ____________________

Risk Factors

Safety Concerns in home ☐ Firearms ☐ Weapons ☐ Pets specify: ____________________

Addictions: ☐ Nicotine/Vaping ☐ Alcohol ☐ Marijuana ☐ Other specify: ____________________

Mental Health Nursing Role Needs of Student

☐ Medication changes/side effects ☐ Medication Education ☐ Addictions support ☐ MH Health System Navigation

☐ Health Teaching (Nutrition, Physical Activity, Sleep Hygiene) ☐ Transition from Hospital ☐ Other specify: ____________________

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Patient History/Pertinent Information *Please attach any relevant Medical History, Medication list and Collateral information

When referrers are unsure of whether a student meets the eligibility criteria, in these times, reach out to (519) 748-2222 ext. 2007 to be re-directed to a Mental Health & Addiction's nurse to discuss further.

REFERER ☐ Inpatient Hospital: ____________ Discharge Date: ________ ☐ Outpatient Clinic: ______

Designation: ☐ Hospital Staff (Nurse, OT, SW) ☐ Psychiatrist ☐ Family Physician ☐ Pediatrician ☐ Community Partner

Referrer Name: ____________________ Signature: ____________________

Contact info: ____________________ Date: ____________________

*Section below, is for MHAN referrals from a school and/or school board

SCHOOL BOARD REFERRER at the following school boards:

☐ UGDSB ☐ Wellington Catholic ☐ WRDSB ☐ WCDSB ☐ Private/Online learning

Referrer Name: ______________ Signature: ________________ Date: ________

Contact #: ________________ Ext: ______ Email: ____________________

HCCSS Child and Youth Mental Health & Addictions Nursing Program

Fax: 1 (519) 571-3957

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