Ontario Health atHome

MENTAL HEALTH & ADDICTION (MHAN)NURSE REFERRAL

PLEASE FAX TO: 1-613-650-2992

Student's Name ______________________

Gender: ☐ Male ☐ Female Other

If Other - Identifies as: Preferred Pronouns: ______________________

Home Address ______________________ __________

City ______________________ Postal Code __________

Phone DOB DD / MM / YY

HCN______________________ VC ________

(HCN entered by hospital or Ontario Health atHome Staff)

Parent/Guardian Contact Information

☐ Mother ☐ Father ☐ Guardian

Name______________________

Home # ______________________

Cell # ______________________

Bus # ______________________

Address ______________________

City Postal Code

☐ Mother ☐ Father ☐ Guardian

Name______________________

Home # ______________________

Cell # ______________________

Bus # ______________________

Address ______________________

City Postal Code

Languages Spoken in Home ☐ English ☐ French ☐ Other Specify

Interpreter Required ☐ No ☐ Yes Specify

Consent Information

Verbal/Written Consent for Referral Obtained from the Student ☐ No ☐ Yes Date DD / MM / YY

Verbal/Written Consent for Referral Obtained from Parent/Guardian ☐ No ☐ Yes Date D D / MM / YY

School Information

School Board ______________________

School Name ______________________ Grade __________

Reason For Referral

☐ Suicidal Ideation / Attempt / Risk to Self/others Specify

☐ Medical Concerns/ Medication Management Specify

☐ Clinical Consultation with DSB staff Specify

☐ Marked changed in presentation Specify

☐ Follow up with student from in-patient Specify

System Navigation included, as needed,for those requiring other services as above Specify

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Alcohol / Substance Misuse ☐ No ☐ Yes ☐ Suspected

Describe:

Please Include Additional Information and Summarize Reason for Referral:
(*i.e. Diagnosis, relevant information supporting reason for referral***)**

Please attach supporting information with this referral:

Medical / Social Work / Psychiatric History	☐ Attached	Medications *(please attached list)*	☐ Attached
Recent Laboratory Results	☐ Attached	D/C Summary	☐ Attached
Paraprofessional reports as relevant	☐ Attached		

School Professional Services Staff Involved

_________________________________ (Name)____(Contact)

_________________________________ (Name)____(Contact)

_________________________________ (Name)____(Contact)

Referral Source:

Name:____Title:_______________________________________

Phone #____ Fax # __________________________________

Signature____ Date: __________________________________

Date referral received by MHAN________________________**Signature** ________________________________