Ontario Health atHome

Mental Health & Addictions Nursing (MHAN) Program Referral Form

Please Fax Completed Referral To: (905) 952-2407 or Email To: MHAN@hccontario.ca
Phone: 905-895-1240 or 416-222-2241 or 1-888-470-2222 Ext. 4365

A. STUDENT'S CONSENT FOR REFERRAL and STUDENT'S INFORMATION

_____ ,
(Student's Full Name – First Name and Last Name)
agrees to the referral to Ontario Health atHome Signed Date *(dd-mmm-yyyy)*: _____

Home Address: _____ DOB *(dd-mmm-yyyy)*: _____

City / Town: _____ Postal Code: _____ Gender: ☐ Male ☐ Female ☐ Other _____

Health Card Number and Version Code: _____

STUDENT CONSENTS TO BE CONTACTED ON THE FOLLOWING NUMBER(S):

Home Phone #: _____ Cell/Alternate Phone # (include Extension): _____

Can we leave a voice mail message at this #? ☐ Yes ☐ No Can we leave a voice mail message at this #? ☐ Yes ☐ No

Is student's first language English? ☐ Yes ☐ No If No, is Interpreter Required: ☐ Yes, Specify language: _____ ☐ No

For hospital referrals, can student be contacted at school? Yes ☐ No ☐

B. STUDENTS CONSENT FOR PARENTS/GUARDIAN TO BE CONTACTED

STUDENT'S CONSENT FOR PARENTS/GUARDIAN TO BE CONTACTED (MANDATORY FIELD) ☐ Yes ☐ No ☐ N/A

☐ Mother ☐ Father ☐ Guardian
Name: _____
Home #: _____
Cell #: _____
Business #: _____ Ext: _____
Is first language English? ☐ Yes ☐ No
If No, is interpreter required? ☐ Yes, Specify: _____ ☐ No
Can we leave a voice mail message? ☐ Yes ☐ No

☐ Mother ☐ Father ☐ Guardian
Name: _____
Home #: _____
Cell #: _____
Business #: _____ Ext: _____
Is first language English? ☐ Yes ☐ No
If No, is interpreter required? ☐ Yes, Specify: _____ ☐ No
Can we leave a voice mail message? ☐ Yes ☐ No

C. SCHOOL INFORMATION

School Board: _____
School Name: _____ Grade: _____
School Address: _____
Phone #: _____ Ext. _____ Fax #: _____
☐ Other Agencies/School Board Services Involved with the Student *(**Please include consultation notes)*
Specify: _____

D. REASON FOR REFERRAL

☐ Mental Health Concern – Please Specify: _____
☐ Mental Health Diagnosis or Medication Management related to Mental Health: _____
☐ Linking to Community Services: _____
☐ Substance Abuse/Misuse (Types): _____
☐ Return to School Support from In-Patient Hospital: _____
☐ Safety Concerns: (e.g. self-harm, suicidal thoughts–plan/attempts): _____
☐ Re-Referral – enter re-referral code (see reverse): _____

E. REFERRAL SOURCE

Hospital/School: _____
Name of staff completing form: _____ Phone #: _____ Ext: _____
Title: _____ Signature: _____ Date: _____ *(dd-mmm-yyyy)*

Complete page 1 – see page 2 for instructions

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Form Completion Instructions

This form is to be completed by the School Staff or Hospital Staff referring student. Submit the completed form (page 1) to the fax number or email address listed on the form (if sent via email it must be password protected – password is MHAN.

Section A – Student's Consent for referral to MHAN program and Student's Information:

- Indicates that the student is aware AND has provided consent for the referral to Ontario Health atHome MHAN services. **Student to provide the contact number where the MHAN nurse is to contact the student at.**
- If the referral source is a hospital, obtain the student's permission allowing Ontario Health atHome MHAN to contact them at their school.

Section B – Student's Consent for Parents/Guardian to be contacted:

- The student controls who we are permitted to speak with, as such, the student must provide the contact information for the individuals that the student has provided consent for the mental health and addictions nurse to contact.
- The referring staff document the Student Consent to contact Parent(s) and / or Guardian and the contact number for Parent(s) and / or Guardian where we may reach the as provided by the student at time of discussing referral to Ontario Health atHome services.

Section C – School Information

- The referring staff member completes this section including the grade that the student is enrolled in at the time the referral is made.

Section D - Reason for Referral – Please select all that apply, below is a list of issues that we provide support for: (use this list to provide additional detail in completing this section)

- Suicidal ideation, intent or attempt
- Self-harm behaviors
- Auditory/visual hallucinations
- Paranoia and/or delusions
- Eating disorders, undiagnosed or not yet linked to mental health supports
- Medication issues, i.e. changes, side effects, poor compliance
- Recent Hospitalization or ER presentation
- Significant substance use, dependency or addiction
- A significant change in baseline mood/emotions
- Extreme emotional state interfering with school engagement/functioning

Re-Referral Criteria Code:

Code	Description	Code	Description
RR1	Readiness to engage	RR2	New/Change in medication or diagnosis
RR3	New safety concerns	RR4	Recent hospital discharge (inpatient/E.D.)

Section E. Referral Source – to be completed by and signed by the referral source – i.e. hospital or school staff completing referral form.

- Hospital/School: If referred by the school, enter school name. If referred by hospital, enter hospital name.
- Name and contact information: enter staff member's name and contact info (phone & ext.) that completed this referral.
- Signature and title of staff member completing referral and date that the form was completed.