HOME AND COMMUNITY CARE SUPPORT SERVICES
Waterloo Wellington

MENTAL HEALTH AND ADDICTIONS NURSING PROGRAM (MHAN)

FAX: (519) 571-3957

Legal name (as it appears on Health Card): _____ 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: _____

Student's Cell Ph: _____ Home phone: _____

Family Doctor: _____Community 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 *ONLY list contacts student has consented for MH nurse to speak with.

☐ Mother ☐ Father ☐ Other ☐ Emergency Contact only

Name: _____

Home ph: _____ Cell ph: _____

Address: _____

City: _____ Postal Code _____

☐ Mother ☐ Father ☐ Other ☐ Emergency Contact only

Name: _____

Home ph: _____ Cell ph: _____

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: _____

☐ I give permission to the MHAN program nurse 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 information will be shared with my school or others without my informed consent.

Health Information ☐ Presenting MH Concerns: _____

☐ Allergies: _____ ☐ Community Agencies: _____

Risk Factors ☐ Suicidal Ideation/attempts ☐ Passive ☐ Active ☐ Historical specify: _____

☐ Relevant Family MH history/stressors specify: _____

Safety Concerns in home ☐ Firearms ☐ Weapons ☐ Smoking ☐ Pets specify: _____

☐ Nicotine/Vaping ☐ Alcohol ☐ Substance Use ☐ Addiction concerns specify: _____

Mental Health Nursing Role Needs of Student

☐ Medication changes/side effects ☐ Medication Education Medication list: _____

☐ Health Teaching (Nutrition, Physical Activity etc.) ☐ Sleep hygiene ☐ Transition from Hospital

☐ MH Health System Navigation ☐ Other specify: _____

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

There may be times 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: _____

*Only complete section below, if you are referring to MHAN program from a school and/or school board

SCHOOL BOARD REFERRER SW, CYW, Psychologist at one of the following school boards:

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

Referrer Name: _____Signature: _____

Contact info/ext.: _____ Date: _____

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.