Community Addiction and Mental Health Services

Services communautaire de santé mentale et de dépendances

Assertive Community Treatment Team (ACTT)
Cornwall, Stormont, Dundas, Glengarry & Akwesasne

ACTT Self-Referral Form

The Assertive Community Treatment Team (ACTT) assists people with complex, serious, and persistent mental health conditions, such as schizophrenia, schizoaffective disorder and bipolar disorder, who may also have co-occurring substance use disorder. An individual, family, or current service provider can make referrals to the program. The team reviews referrals on a weekly basis. An assessment will be completed to determine eligibility for ACTT services.

ACTT excludes individuals with a **primary** diagnosis of a personality disorder, substance use disorder, dementia, development disabilities or those whose clinical and/or behavioral needs cannot be safely supported in the community.

Services include:

- Identifying and achieving individual goals (such as life skills, education, financial, recreation, etc.)
- Symptom assessment, management and education
- Supportive counselling and psychotherapy related to mental health and/or substance use health
- Medication education, prescription administration and monitoring

Should you have any questions or require assistance with filling in this form, please call 613-361-6363 ext. 8790 and a staff person will be happy to help you.

Please ensure that all pertinent information is included with referral:

- ✓ Current list of medications (past and current)
- ✓ Client Consent (signed by client and witness)
- ✓ Consultation reports or other significant documents within past 2 years

Mail or fax the completed application form to:
Community Addiction & Mental Health Services
Attention: ACTT
850 McConnell Ave. Cornwall ON K6H 4M3

Telephone: 613-361-6363 ext. 8790 **Toll free:** 1-844-361-6363
Fax: 613-361-6364 Attention: ACTT

Please note that all incomplete referral forms will be returned to the sender.

ACTT SELF-REFERRAL FORM

Date of Referral (dd/mm/yyyy): _____

SECTION 1: Client Information

Last Name: _____ First Name: _____

Marital Status: _____ Date of Birth (dd/mm/yyyy): _____

How do you identify your gender? Select all that apply.

☐ Woman ☐ Man ☐ Genderqueer or genderfluid ☐ Non-binary ☐ Questioning or unsure ☐ Two-spirit
☐ Do not know ☐ Prefer not to answer ☐ Another gender identity: _____

Do you identify as transgender? ☐ Yes ☐ No ☐ Do not know ☐ Prefer not to answer

What pronouns would you like us to use?

☐ He/Him/ His ☐ He/They ☐ She/Her/Hers ☐ She/They ☐ They/Them/Theirs

Address: _____

What type of housing do you presently live in (i.e. rent, no fixed address, supportive housing, etc.)?
_____

Telephone #: _____ Can a confidential message be left at this number? ☐ Yes ☐ No

Indigenous: ☐ Yes ☐ No Language: ☐ English ☐ French ☐ Other: _____

Health Card #: _____ Version Code: _____ Expiry Date: _____

Emergency Contact Name: _____ Emergency Contact #: _____

Highest Level of Education: _____

SECTION 2: Reason for Referral

Brief description of symptoms and diagnosis:

PSYCHIATRIC DIAGNOSIS AND HEALTH:

Primary Diagnosis: _____ Secondary Diagnosis: _____

Disabilities and/or special considerations: _____

_____

Age of onset of illness: _____

CURRENT MEDICATIONS: *Please attach a separate sheet, if required.*

HOSPITALIZATIONS: *Please include dates, duration, and institution. Please add a separate sheet, if required.*

Age of first hospitalization: _____

DATE	DURATION	INSTITUTION

HOUSING SECURITY:

Have you experienced homelessness in the last two years? If so, please include dates. ☐ Yes ☐ No

Dates: _____

SUBSTANCE USE:

Do you struggle with substance use? ☐ Yes ☐ No

Has there been any treatment in the past or present? ☐ Yes ☐ No
If yes, please specify (including the treatment program/facility):

FUNCTIONAL ABILITIES:

The client (you):	Yes	No
Meets basic needs *(housing, food)*		
Carries out activities of daily living required for basic functioning in the community *(i.e. getting to and from places, medical care, personal hygiene)*		
Maintains safe housing *(no eviction nor loss of housing)*		
Maintains vocational activity *(school, volunteering, or employment)*		
Has family support and/or social network involvement		
Has a history of suicide attempts/ideation		
Has a history of harm to others or self		
Has been declared financially incompetent		
Has a Public Guardian and Trustee		
Has been declared incompetent to make treatment decisions		
Has a Substitute Decision Maker (if yes, provide contact information below)		

_____ _____ _____
Substitute Decision Maker Name Relationship Telephone

LEGAL:

Do you have any pending criminal charges or upcoming court dates? ☐ Yes ☐ No
If yes, please list:

Reasons/charges: _____

Court Order: _____

Are you under a Community Treatment Order? ☐ Yes ☐ No

Date of issuance (dd/mm/yyyy): _____ Issuing Physician: _____

Have you been declared Not Criminally Responsible? ☐ Yes ☐ No

OTHER SERVICES INVOLVED:

NAME	ADDRESS	TELEPHONE

Has this referral and potential assessment been discussed with:

Family/Substitute Decision Maker: ☐ Yes ☐ No

Other (specify): _____

VIOLENCE/AGGRESSION ASSESSMENT

Known history of violence: ☐ Past history ☐ Current history ☐ None

BEHAVIOUR AND RISK

Please indicate if you have recently exhibited any of the following type of behaviour below:

☐ Uncooperative ☐ Verbal abuse ☐ Hostile/attacking objects

☐ Threats ☐ Assaultive/combative ☐ No aggressive behaviour exhibited

Known risk factors/triggers *(enter 'none' if there are no known risk factors/triggers or if this question is not applicable)*

Mitigation strategies for known risk factors/triggers *(enter 'none' if there are no known mitigation strategies or if this question is not applicable)*

Level of risk: ☐ Low ☐ Moderate ☐ High

Current risk mitigation strategies/intervention *(enter 'none' if there are no risk mitigation strategies/ intervention)*

Additional Comments:

Assertive Community Treatment Team
Client Consent

The Assertive Community Treatment Team (ACTT) is a multidisciplinary team that works with multiple community service providers. To make the process easier, we request your permission to discuss your referral with the team and with other service providers involved in your care.

Please sign below to give your consent.

_____	_____	_____
Client Name (please print)	Client Signature	Date (dd/mm/yyyy)

If you are not the client, state your name and relationship to the client and sign below:

_____	_____	_____	_____
Name (please print)	Signature	Relationship	Date (dd/mm/yyyy)

_____	_____	_____
Witness Name (please print)	Witness Signature	Date (dd/mm/yyyy)