Community Addiction and Mental Health Services
Services communautaires de santé mentale et de dépendances

Revised June 3, 2019

COMMUNITY ADDICTION AND MENTAL HEALTH SERVICES

Cornwall Community Hospital
850 McConnell Avenue, Cornwall, ON K6H 4M3
613-361-6363 Ext. 8764 / Fax: 613-361-6364

This form is for non-urgent referrals: if you require urgent mental health care contact the Distress Centre at 1-866-996-0991
For active withdrawal symptoms please contact Community Withdrawal Management Services (Cornwall) at 613-938-8506

CLIENT INFORMATION

Name (last, first name):_____ Preferred Name:_____

Date of Birth (yyyy/mm/dd):_____ Health Card #:_____

Address:_____

City:_____ Postal Code:_____ Email:_____

Preferred Contact #:_____ Can a confidential message be left at this number? ☐Yes ☐No
Alternate Contact #:_____ Can a confidential message be left at this number? ☐Yes ☐No
Main spoken language? ☐English ☐French Other: _____ Interpreter required? ☐Yes ☐No
Francophone? ☐Yes ☐No French language services required? ☐Yes ☐No
Gender: ☐Male ☐Female ☐Trans – Female to Male ☐Trans – Male to Female ☐Intersex ☐Two-Spirit
☐Other ☐Prefer not to answer ☐Do not know

REASON FOR REFERRAL - INFORMATION REGARDING CLIENT'S SITUATION

_____
_____
_____
_____
_____
_____

Mandated Treatment? ☐ Yes ☐ No By whom: _____
Psychiatric Diagnosis? ☐ Yes ☐ No ☐ Unknown
Current or Previous Mental Health Services _____

CURRENT MEDICATIONS

_____

Attach Current Medication List or provide name of Pharmacy: _____

CONSENT

Is the client aware of and in agreement with this request for service? ☐Yes ☐No
Does the client consent to the sharing of this referral with IASP service providers? ☐Yes ☐No

REFERRAL SOURCE

Referrer Name (last, first name): _____ Date of Referral (yyyy/mm/dd): _____
Type: ☐Family Physician ☐Nurse Practitioner ☐Psychiatrist ☐Psychologist ☐Other Clinician ☐Self
Billing number (if applicable): _____ OHIP registration number (if applicable): _____
Address: _____
Telephone: _____ Fax: _____
Signature: _____

FAMILY PHYSICIAN / NURSE PRACTITIONER

Name: _____
Address: _____
Telephone: _____ Fax: _____
Signature: _____ Date: _____

The Royal / Le Royal
Mental Health - Care & Research
Santé mentale - Soins et recherche

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PRIMARY CARE PROVIDER ONLY

REFERRAL TO
Increasing Access to Structured Psychotherapy Champlain

SERVICE DESCRIPTION
Adults can now access publically funded Cognitive Behavioural Therapy (CBT) as part of Ontario's Increasing Access to Structured Psychotherapy (IASP) program, led in the Champlain region by The Royal. CBT is a goal-oriented, time-limited therapy that helps clients by teaching practical skills and strategies to manage their mental health and improve quality of life. Clients will work individually with IASP therapists for approximately 12 sessions either in person or via telemedicine at The Royal or within IASP community partner agencies located throughout the Champlain region.
BounceBack® may be considered prior to IASP, has your client / patient been referred to BounceBack®? ☐ Yes ☐ No

ELIGIBILITY CRITERIA	YES	NO
Primary diagnosis of: Depression	☐	☐
- Anxiety Disorder(s), including: generalized anxiety disorder, panic disorder, agoraphobia, social anxiety disorder, specific phobia, and health anxiety	☐	☐
- Obsessive-Compulsive Disorder	☐	☐
- Post-Traumatic Stress Disorder	☐	☐
Resident of Ontario	☐	☐
Adult (18+)	☐	☐
NOT SUITABLE IF:	**YES**	**NO**
Actively suicidal and with impaired coping skills and/or has attempted suicide in the past 6 months	☐	☐
At high risk to harm self or others or at significant risk of self-neglect	☐	☐
Experiencing significant symptoms of mania or hypomania currently or has experienced these symptoms within the past year	☐	☐
Experiencing significant symptoms of a psychotic disorder currently or has experienced these symptoms within the past year	☐	☐
Has a severe/complex personality disorder that would impact their ability to actively participate in CBT for anxiety or depression	☐	☐
Has a moderate to severe impairment of cognitive function (e.g. dementia); or moderate / severe impairment due to a developmental disability or learning disability which would impact their ability to participate in CBT	☐	☐
Has problematic substance use or has had problematic substance use in the past three months that would impact their ability to actively participate in CBT. Requires specialized concurrent disorders treatment.	☐	☐
Has a severe eating disorder that would impact their ability to actively participate in CBT for anxiety or depression	☐	☐

IASP STAFF to complete

Date referral received (yyyy/mm/dd): _____ Date referral complete (yyyy/mm/dd): _____

Intake Decision: _____ Date of decision (yyyy/mm/dd): _____

Delivery Site: _____ Service Delivery Type: ☐ In person ☐ Telemedicine

Date of first appointment with client / patient (yyyy/mm/dd): _____ Therapist: _____

The Royal
Mental Health - Care & Research
Santé mentale - Soins et recherche

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REFERRAL - IASP CHAMPLAIN

PHQ-9

During the **last 2 weeks**, how often have you been bothered by the following problems?

Problem	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching TV	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Total score: ☐

If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

GAD-7

During the **last 2 weeks**, how often have you been bothered by the following problems?

Problem	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total score: ☐