Shared health Soins communs Manitoba

Mental Health and Addictions
Behaviour Resource and Consultation Team (BRaCT)

REQUEST FOR CONSULTATION

Phone: 204-430-2867 Fax: 204-779-9165

MRN: #:

Last/First Name:

Date of Birth (dd/mmm/yyyy)

Sex: ☐ Female ☐ Male

PHIN:

MB Reg #:

CLIENT INFORMATION

Address:	Postal Code:	Phone
Interpreter Required: ☐ Yes ☐ No Language:		
Is the client aware of Request? ☐ Yes ☐ No Has the client consented to Request? ☐ Yes ☐ No *Refer to script within Guideline under Specific Instructions and confirm on p.2 of Request under "Consent".*	If no to either question, explain:	

MENTAL HEALTH DIAGNOSIS

☐ Anxiety Disorder ☐ Autism Spectrum Disorder ☐ Bipolar and Related Disorders	☐ Depressive Disorder ☐ Intellectual Disability ☐ Neurocognitive Disorder	☐ Personality Disorder ☐ Schizoaffective Disorder ☐ Schizophrenia	☐ Substance Use Disorder ☐ Trauma and Stress Related Disorders ☐ Other (List)

RELEVANT PHYSICAL HEALTH DIAGNOSES/ISSUES

Any relevant assessments completed within the last year? ☐ Yes ☐ No ☐ Attached

SERVICE INVOLVEMENT

Psychiatrist: ☐ Yes ☐ No
Name of Psychiatrist:
Address:
Phone
Fax

Community Mental Health: ☐ Yes ☐ No
Name of Worker:
Service/Team/Site:
Phone
Fax

Primary Care Provider (PCP) (e.g. Physician, Nurse Practitioner)
Name of PCP:
Address:
Phone
Fax

Community Living disAbility Services: ☐ Yes ☐ No
Name of Community Services Worker:
Phone
Fax

Home Care: ☐ Yes ☐ No
Name of Case Coordinator:
Phone
Fax

Other (e.g. Geriatric Mental Health Team, Clinical Psychology, Community Therapy Services):

Legal/Financial Arrangements: (check all that apply)
☐ Self ☐ Power of Attorney ☐ Substitute Decision-Maker ☐ Office of the Public Guardian and Trustee ☐ Committeeship - Order of Committeeship held by:
☐ family member
☐ Office of the Public Guardian and Trustee

LIVING SITUATION

☐ **Independent Living**	**Describe:**		
☐ **Special Contract Housing**	**Agency:**	**Agency Contact Person:**	**Phone**
☐ **Residential Care**	**Home Provider:**	**Home Contact Person:**	**Phone**
☐ **Transitionally/ Precariously Housed**	**Describe:**		
☐ **Other**	**Describe:**		

Is there a Safe Visit Plan? ☐ No ☐ Yes ☐ Attached

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CONSENT

Is it okay for us (i.e., your service providers) to share written and verbal information about you with BRaCT? ☐ Yes ☐ No
Is it okay for someone from BRaCT to meet with you to ask about your daily life? ☐ Yes ☐ No
Is it okay for someone from BRaCT to talk to us (i.e., your service providers) about you? ☐ Yes ☐ No

Date of Verbal Consent: D D M M M Y Y Y Y	Consent obtained by (Name and Designation):	Location:

DESCRIPTION OF SITUATION

Risk Factors:

☐ Abuse from Others	☐ Distressed Thinking or Feeling	☐ Unintentional Self-Harm
☐ Abuse towards Others	☐ Intentional Self-Harm	
☐ Difficulties with Activities or in Relationships with Others	☐ Limitation of Basic Amenities, Resources, Skills	

DESCRIBE CURRENT SITUATION *(May include: functional issues/changes; relationship/social features; risk to self & others, criminal justice system involvement)*

WHAT IS THE PRIMARY BEHAVIOUR OF CONCERN?

WHAT MAKES THE BEHAVIOUR CONCERNING?

EXPECTATION FOR CONSULTATION

Duration of Behaviour or Change in Behaviour:	Does the individual have multiple hospital visits within the last 12 months? ☐ Yes ☐ No Is the individual currently admitted to hospital? ☐ Yes ☐ No Indicated Hospital/unit: _____ Is individual medically and psychiatrically stable? ☐ Yes ☐ No

CONSULT SOURCE INFORMATION

Printed Name and Designation of Consult Source:	**Signature of Consult Source:**	**Date of Consult Request:** D D M M M Y Y Y Y

Title of Consult Source: _____ **Phone** - -

Service/Team/Site: _____ **Fax** - -

Printed Name and Title of Authorizer: (e.g. Team Manager, Clinical Specialist)	**Signature of Authorizer:**