Shared health
Soins communs
Manitoba

ASSERTIVE COMMUNITY TREATMENT PROGRAMS REFERRAL

Date of Referral:________________________________

Application to the which of the following:
(Please check service referring to)

- ☐ **Flexible Assertive Community Treatment (FACTT)**
- ☐ **Assertive Community Treatment (ACT)**
- ☐ **Program of Assertive Community Treatment (PACT)**
- ☐ **Uncertain**

REFERRAL SOURCE:	
Name:	
Facility / Unit / Organization:	
Address:	
Phone Number:	Fax Number:

APPLICANT INFORMATION:		
Name:	Gender: Pronouns:	Date of Birth: / / Day / Month / Year
Address: Postal Code:		Manitoba Health Services Number (6): Personal Health Information Number (9):
Phone Number (H): Can this number be texted? Y / N		Phone Number (W): Email:
Alternate Contact (with permission of individual) Name: Relationship:		Phone Number: Alternate Number:
First Language: Ethnic background (optional):		Interpreter Required: Yes No
Treaty number (optional):		Band (optional):
Family Physician: Clinic Name:		Phone Number: Fax Number:
Current Psychiatrist:		Phone Number:
Current CMHW		Phone Number:
Other Support (formal, organizational)		Phone Number:
Currently Admitted to Hospital: Yes No		Name of Hospital:
List unit individual admitted to if currently in hospital:		

REASON FOR REFERRAL: (Please include symptoms, duration, and history of treatment. Attach additional pages if needed)

PSYCHIATRIC DIAGNOSIS: (indicate all that apply)	**YES**	**NO**	**COMMENTS (TYPE)**
Anxiety Related Disorders			Please identify
Bipolar Disorder			Please specify type:
Depression			
Eating Disorder			Please specify type:
Unspecified psychotic disorder			
Personality Disorder / Traits			Please specify type:
Post Traumatic Stress Disorder			
Schizoaffective Disorder			
Schizophrenia			
Substance Use Disorder			
History of known neurodevelopmental disability? (i.e. Autism spectrum disorder, ADHD)			Describe:
Is there a formally diagnosed intellectual developmental disorder (IDD)?			Clinical severity:
Are there cognitive challenges?			Describe:
Other: (Organic Brain Damage, Traumatic Brain Injury, Genetic Disorders, etc.)			Describe:
History of Trauma			
Does the individual have a history of self-harm or previous suicide attempts? If yes please attach any suicide risk assessment and safe plan.			

ASSESSMENTS / REPORTS:
Please attach reports

	Yes	**No**	**Comments**
Does the individual have any psychological testing / report completed? Includes school or medical			
Does the individual have an occupational therapy assessment?			
Does the individual have a social work report?			
Does the individual have a recent psychiatric assessment?			
Does the individual have a speech language assessment?			

PRIOR PSYCHIATRIC ADMISSIONS (attach additional pages if needed):			
Facility	**Date Admitted**	**Date Discharged**	**Reason for Admission (Please include if voluntary or involuntary)**

MEDICATIONS: Attach Medication Administration Record (MAR) if one available.

Name	Dosage & Frequency	Side Effects	Taking As Prescribed Yes or No

SUBSTANCE USE HISTORY:

	YES	**NO**
Does the individual use any drugs or alcohol?		
Does the individual have a past history of drug or alcohol use?		
Does the individual think their drug or alcohol use is problematic?		
Has the individual been in residential treatment? Please list:		
Has the individual been involved with CODI?		
Has the individual been treated for an Opioid Use Disorder (OUD)?		
Is the individual currently receiving Opioid Agonist Therapy (OAT)?		

CURRENT SUBSTANCE USE:

Substance	**Frequency of Use**	**Amount Uses**	**Last Used**	**Comments**
Alcohol				
Marijuana / Cannabis				
Cocaine				
Ecstasy				
Hallucinogenics				
Inhalants				
Methamphetamine				
Opioids				
Over the counter medications				
Prescription medications (overusing / is someone else's)				
Other: (Please specify)				

MEDICAL HISTORY		Yes	No	Comments (Include previous history of illness if applicable)
Medical Diagnoses:				:
Arthritis				
Asthma				
Cancer	Type:			
Diabetes	Type 1: ☐ Type 2: ☐			
Hepatitis C				
HIV				
Seizures				
Neurological disorders				
Thyroid Disorder				
Cardiovascular disease:				
Does the individual require any medical follow up?				
Does the individual receive homecare? Case Coordinator & Phone Number?				What for? Frequency of services?
Has the individual had any surgeries?				Type of surgery: When: Where:
Has the individual ever been admitted to hospital for a medical reason?				Reason: When: Where:
Does the individual have any medical aids? (Walker, dentures, prosthetics, glasses, etc.)				
Other medical issues / illness:				Describe:
Allergies				List: Reaction:

PARTICIPANT INFORMATION	YES	NO	COMMENTS
Does the individual live with family?			
Does the individual live alone?			
Is the individual homeless / at risk of eviction?			
Does the individual agree with the referral?			

FAMILY HISTORY:	If there is a social or family history please attach.
Members of family of origin? (biological, adoptive, foster)	
Describe current family supports?	
Describe quality of relationships with family?	
Is there any family history of mental illness?	

Please Describe Any Community Options that were tried to support individual in community (i.e. group home, CMHW, community outreach, day centres)
How Successful it was for the Individual (i.e. group home, CMHW, Community outreach, day centers)

COMMUNITY SUPPORTS:	
Who would the individual consider their main supportive persons?	
Are there any community organizations that the individual finds helpful?	
Are there any community organizations that the individual has tried and not found helpful? Why?	
What organization does the individual have the most contact with?	
Has the individual participated in counselling / therapy?	Please specify:
When in a difficult situation (crisis), who does the individual contact for support?	

EDUCATIONAL AND VOCATIONAL INFORMATION	YES	NO	COMMENTS
How many years of education has the individual completed?			
Did the individual have an educational assistant during schooling?			
Was the individual in special education classes?			
Is the individual currently enrolled / registered in an educational program?			
Does the individual want to return to school?			
Is the individual currently working?			
Has the individual ever worked?			
Does the individual want to work or volunteer? If so, what areas are of interest to them?			
CURRENT FINANCIAL MANAGEMENT	**YES**	**NO**	**WORKER CONTACT INFORMATION & CASE NUMBER**
Self			
Power of Attorney			Please name individual:
Order of Committeeship (Public Trustee)			
EIA			
CPP			

CURRENT LEGAL STATUS	YES	NO	COMMENTS
Voluntary Client			
Involuntary Client Under the Mental Health Act			
Certificate of Leave			
Under Criminal Code Review Board (CCRB)			
Has a Health Care Directive			Please attach if copy available.
Probation Order			Please attach if copy available. Name of probation officer:
Restraining / Protection Order			Individual restraining order is in regards to:
Current Charges			
History of Incarcerations:			
Is there an upcoming court date?			When:
Does the individual have a history of being physically, verbally, or sexually aggressive?			
Does the individual have a safe visit plan? If yes please attach the plan.			

Please State Strengths of the Individual (values, interests, spirituality, hobbies, sports):

Please describe what supports the individual would benefit from?

Does the individual have any goals that they would like the teams to be aware of?

Additional Information:

TO PREVENT DELAYS IN THE INTAKE PROCESS, PLEASE ATTACH ANY SUPPORTING DOCUMENTS:

DOCUMENT	YES	NO
Psychiatric Assessment Report		
Psychological Reports		
Other Assessments / Consult Reports (Occupational Therapy, Social Work, etc)		
Admission and Discharge Summaries		
Diagnostic Test Results (CT scans, MRI's, EKG, EEG)		

Completed By:	
Date Completed:	
Signature:	

PLEASE FAX YOUR COMPLETED REFERRAL TO: 204-944-6382 or Mail to HUB 1031 Portage Ave Wpg, MB. R3G 0R8

Any questions please call 204-944-6395

*****PLEASE NOTE THAT AN INITIAL ASSESSMENT APPOINTMENT DOES NOT MEAN THE INDIVIDUAL HAS BEEN ACCEPTED AND YOU MUST CONTINUE TO PROVIDE SERVICES TILL INDIVIDUAL IS OPENED TO A TEAM*****

FOR HUB USE ONLY:

Recommendation regarding screening:	YES	NO	COMMENTS
Date Referral Received to HUB			
Candidate for: Program of Assertive Community Treatment (PACT) Flexible Assertive Community Treatment (FACTT) Assertive Community Treatment (ACT)			
Appointment Set Up for Initial Psychiatric Assessment			Date and Time: With Whom:
Assessment Sent to: PACT Hargrave PACT Leila PACT Logan PACT Winnipeg West Flexible ACTT ACT			
Accepted to: PACT Hargrave PACT Leila PACT Logan PACT Winnipeg West Flexible ACT ACT			
Not appropriate for: (Please explain why) Program of Assertive Community Treatment (PACT): Flexible Assertive Community Treatment (FACTT) Assertive Community Treatment (ACT)			
Letter sent to Referral Source with Outcome of Assessment and Recommendations			Date sent: