Interior Health
Every person matters

COK ASSERTIVE COMMUNITY TREATMENT (ACT)

Person Completing Referral: _____ Date: _____

Referring MHSU Case Manager (if applicable): _____ Phone #: _____

Referring Psychiatrist (if applicable): _____ Phone #: _____

CLIENT DEMOGRAPHICS

Last Name: _____ First Name: _____

DOB: (DD-MMM-YYYY) _____ PHN: _____

Client Phone #: _____ Is Client Aware of Referral? Yes No

Current Address: _____

ESTABLISHMENT OF ASSERTIVE COMMUNITY TREATMENT (ACT) ADMISSION CRITERIA

1. Primary psychiatric diagnosis (confirmed on psychiatric consult, please include):

_____

Other psychiatric diagnosis (confirmed on psychiatry consult, please include):

_____

2. Significant functional impairments due to severe and persistent mental health condition as demonstrated by at least two of the following:

☐ Inability to consistently perform a range of basic activities of daily living (e.g., personal hygiene, communicating, accessing and navigating the community, managing medications, eating, managing health and safety, managing personal finances, etc.). Please describe: _____

_____

_____

☐ Difficulty adhering to treatment recommendations (e.g. injectable and/or oral medication, attending follow up appointments with psychiatrist, engaging with MHSU supports, participating in psychosocial rehabilitation plan, etc.). Please describe: _____

_____

_____

☐ Unstable housing (e.g. repeated evictions, inability to consistently maintain a safe living situation, etc.). Please describe: _____

_____

_____

3. High use of hospital psychiatric services (>50 hospital bed days in a year):

- Number of acute psychiatric admissions in the past year: _____
- Number of ED presentations in the past year: _____
- Number of days in tertiary care in the past two years: _____

4. Indicators for high service needs – client presents with one or more of the following:

☐ Severe and persistent psychiatric symptoms that are difficult to treat/manage.

☐ Coexisting substance use disorder of greater than 6 months.

☐Involvement with the criminal justice system *at a level of risk that is manageable in the community*. ▪

Number times in custody/jail in the past year: _____

- Number of contacts with RCMP in the past year: _____

☐ Inability to consistently meet basic survival needs, residing in substandard housing, homeless, or at imminent risk of becoming homeless.

☐ Traditional office-based and intensive case management services have been unsuccessful.

- Number of documented outreach visits in the past month: _____
- Number of documented outreach attempts in the past month: _____
- Number of Extended Leave Recalls in the past year and reason(s): _____

_____

_____

REASON(S) FOR REFERRAL TO ASSERTIVE COMMUNITY TREATMENT (ACT) Why are you referring your client to ACT?

What are the current barriers to providing service and support?

What has been trialled to address the barriers described above?

CLINICAL CONSIDERATIONS

Is the client certified under the Mental Health Act? No ☐ Yes ☐ Date of Expiry: _____

Is client on an LAI? No ☐ Yes ☐ Next Due Date: _____

Psychiatric medications/interventions trialled to date:

_____

_____

_____

Please list any general medical conditions and describe current treatment/management plan:

_____

_____

_____

_____

_____

Does the client have a documented or suspected intellectual or neurodevelopmental disability? No ☐ Yes ☐

If yes, then please provide details (e.g., diagnosis, service connections, impact on client's day-to-day functioning, etc.):

_____

_____

_____

_____

RISK FACTORS AND SAFETY CONCERNS

History of Violence	☐Current	☐ Past	☐ None
History of Verbal Aggression	☐Current	☐ Past	☐ None
History of High Police Involvement	☐Current	☐ Past	☐ None
History of Suicidal Ideation	☐Current	☐ Past	☐ None
History of Suicide Attempt(s)	☐Current	☐ Past	☐ None

If current or past, then please provide details below:

SUBSTANCE USE

Substance 1 _____ Days of use/Week _____ Route _____ Typical Amount used at each event_____

Substance 2 _____ Days of use/Week _____ Route _____ Typical Amount used at each event_____

Substance 3 _____ Days of use/Week _____ Route _____ Typical Amount used at each event_____

Previous or current treatment (please inlcude dates):

_____

_____

How has client responded to previous substance use interventions (e.g. Withdrawal Management, iOAT, Abstience, Harm Reduction, etc.)?:

_____

_____

_____

Overdose Risk: ☐Low ☐ Medium ☐ High

HOUSING ***Please complete this section if the client is homeless or precariously housed****

How long has client been experiencing homelessness for? _____ Years _____ Months

Please describe past and current barriers to securing and maintaining housing: _____

_____

_____

_____

What has been trialled to address the barriers described above? _____

_____

_____

_____

Has a VAT been completed? ☐ No ☐ Yes Date completed: _____ *FINANCES*

Client's Current Source of Income: _____ Monthly Amount (if known): _____

Eligible for Plan G? ☐ Yes ☐ No

If not, then please describe how client's medication(s) are funded: _____

INVOLVEMENT WITH CRIMINAL JUSTICE SYSTEM

Is client on Probation ☐ Yes ☐ No

If yes, then please provide details including current conditions and end date (if known):

_____

_____

Any charges pending? ☐ Yes ☐ No

If yes, then please provide details:

_____

_____

P.O. Contact information: Name: _____

Office: _____

Any past or current involvement with forensic mental health services? ☐ Yes ☐ No

If yes, then please provide details:

_____

_____

OTHER CLINICAL CONSIDERATIONS

_____

_____

_____

_____

_____

SUPPORTING DOCUMENTATION – MUST BE INCLUDED WITH REFERRAL

☐ Current Medication Profile (if in hospital) or Best Possible Medication History (BPMH) (if in community)

☐ List of hospitalizations from the past 2 years, including:

- Name of hospital
- Reason for admission
- Length of stay

☐ Psychiatry consults and discharge summaries (past 2 years)

☐ Most recent functional assessment completed by an Occupational Therapist (if available)

☐ Most recent psychology assessment report (if available)

☐ All care plans/case reviews completed within the past year

DOCUMENTATION REQUIRED UPON ACCEPTANCE (PRIOR TO OPENING TO SERVICE)

☐ Form 4.1 and Form 4.2 – completed as per Mental Health Act requirements up to current date

☐ Form 6 – completed as per Mental Health Act requirements up to current date

☐ New Form 20

☐ Form 15

☐ Transfer Agreement for an Involuntary Patient

Please email completed referral form and required supporting documentation to:

ACT_Referral@interiorhealth.ca

Please note that incomplete referrals will not be processed and that the referral source may be invited to a teleconference or virtual meeting with the ACT Referral Screening Committee if additional information is required in order to make a more informed decision about whether to accept or decline.

Please also note that referrals cannot be made to a specific ACT Team. All referrals are reviewed by members from both ACT Teams. Team assignment and anticipated admission date is decided after a referral is accepted and is based on each team's capacity for intake.