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

____
____
____
____
____

REQUIRED SUPPORTING DOCUMENTATION

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

☐ List of hospitalizations including name of hospital, reason for admission and length of stay for the past 2 years

☐ Psychiatry Consults and Discharge Summaries for the 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 last year

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.