Homewood
Health Centre

Date of Referral: _____

REFERRAL FORM FOR ADMISSION TO HOMEWOOD HEALTH CENTRE

PATIENT INFORMATION

Patient Name:		
Address:		
City:	Province/State:	Postal/Zip Code:
Country:	E-mail Address:	
Telephone:	Business/Mobile Phone:	
Date of Birth (YYYY-MM-DD):	Gender:	
Health Card #:		
Version Code:	Expiry Date:	
Department of National Defence Blue Cross Service # (if applicable):		
Veterans Affairs Canada K # (if applicable):		
Accommodation Requested: □ Ward □ Semi-private/Private □ Unknown		
Additional health insurance coverage? □ No □ Yes □ Unknown		

REFERRING CLINICIAN INFORMATION

Name:		
Your role: □ GP/FM Practitioner □ Psychiatrist □ Psychologist □ Therapist □ Nurse Practitioner □ Social Worker □ Counsellor □ EFAP □ Other: _____		
Address:		
City:	Province/State:	Postal/Zip Code:
Country:	E-mail Address:	
Telephone:	Fax:	
OHIP Billing # (if referred by a doctor):		
Are you referring as part of: □ WSIB □ DND □ VA □ Other Agency:		

In order to arrange a timely admission to the most appropriate program, please provide us with up-to-date information, dating back at least two years. Copies of past consults, test results and discharge summaries are most helpful.

Has this patient been admitted to Homewood before? □ No □ Yes

Reason for Referral:

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Patient Name: _____

Please circle all the problems your patient has and underline their biggest problem:

Eating Disorder
Substance Abuse (drug and/or alcohol)
Addiction (drug and/or alcohol)
Chronic Pain
History of Abuse or Trauma
PTSD (post-traumatic stress disorder)
Self-Harm
Suicidality
Bipolar Disorder
Major Depression
Hypomania
Mania
Violence
Aggression
Dementia
Cognitive Disorder
(head injury, memory problems)
Social Phobia
Panic Disorders
OCD (Obsessive Compulsive Disorder)
ADHD (Attention Deficit Hyperactivity Disorder)
Personality Disorder
Schizophrenia
Acute Psychosis
(thought disorder/hallucination/delusion)
Chronic Psychosis
(thought disorder/hallucination/delusion)

SAFETY

Does the patient currently have suicidal ideation? □ No □ If Yes, do they have a plan? □ No □ Yes
Past suicidal behaviours? □ No □ If Yes, please explain in Safety Comments section below.
Date of last suicide attempt:
Is there a history of chronic self-injury? □ No □ If Yes, please explain in Safety Comments section below.
Is homicidal ideation present now? □ No □ If Yes, please describe in Safety Comments section below.
History of setting fires? □ No □ If Yes, please explain in Safety Comments section below.
Past criminal charges? □ No □ Unknown □ If Yes, please specify:
History of assault or violence? □ No □ If Yes, please specify:
SAFETY COMMENTS (e.g., describe method of suicide attempts or plans):

GROUP READY

Is the patient aware of this referral?	□ Yes	□ No
Is the patient motivated to engage in treatment?	□ Yes	□ No
Is the patient able to participate in a group-based program?	□ Yes	□ No
Is the patient able to reside on an unlocked unit?	□ Yes	□ No
Does the patient have a substitute decision maker?	□ Yes	□ No
Is the patient subject to a Community Treatment Order (CTO)?	□ Yes	□ No

CURRENT MEDICATIONS (psychiatric and other, e.g., insulin. Please attach a list if necessary.)

Name	Dosage	Frequency	Reason for Use

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MEDICAL INFORMATION (Please attach a list if necessary.)

Physical health/conditions:
Any physical limitations or special needs? □ No □ If Yes, please describe:
Please identify any of the following that may apply to this patient: *limited vision or hearing, learning disabilities, intellectual or developmental disabilities, cognitive or memory problems, speech or language impairment, language barriers, does not speak English, etc.*
Is the patient able to walk, feed, dress, bathe and care for self? □ Yes □ If No, please describe:
Physical nursing care required? □ No □ If Yes, please describe:
Does the patient suffer from Chronic Pain? □ No □ If Yes, is it stable? □ No □ Yes
Is the pain managed by narcotics? □ No □ If Yes, please provide dosage and frequency on Page 2 of this form.

Current Height:	Current Weight:

Please indicate if the patient has tested positive for any of the following infections:

□ C-Difficile □ Hepatitis □ HIV □ MRSA □ VRE □ Other:

Comments:

Has the patient had any psychiatric and/or medical hospitalizations within the last five years?
□ No □ If Yes, where, when and why?

Please forward discharge notes or consults from hospital stays.

Is the patient currently in a hospital? □ No □ If Yes, where? _____	
Admission date:	Projected discharge date:
Reason for current admission:	
Duration of current episode:	

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ADDICTION

Does the patient currently have any drug or alcohol issues? □ No □ Yes
If yes, substance(s) of choice: _____ □ Oral □ Smoked □ Snorted □ IV
Length of consumption: Amount consumed per day:
Has the patient ever experienced severe withdrawal symptoms from alcohol or drugs (e.g., DTs, seizures or hallucinations)? □ No □ If Yes, describe:
Is the patient currently detoxified? □ No □ Yes
Last use of alcohol: Last drug use:
What losses has the patient suffered due to their addictive behaviour? (i.e., relationships, job, legal, financial losses)
Does the patient admit to having a problem? □ No □ Yes

METHADONE OR SUBOXONE USE ***(note: some programs have specific admission requirements concerning methadone treatment.)***

Is the patient currently being prescribed Methadone or Suboxone as a treatment for addiction or pain? □ No □ If Yes, please indicate current dose and length of time on that dose:
Name and contact information of Physician prescribing Methadone or Suboxone (if applicable):
Is the patient willing to taper off Methadone or Suboxone, if necessary? □ No □ Yes
Is the patient using medical marijuana? □ No □ Yes

If you are referring to the **Eating Disorders Program**, medical and lab requests will be forwarded to the patient. The forms are to be completed by your patient's Medical Doctor and forwarded to Admitting as soon as possible. The patient must reduce/stop laxatives and diet pills, etc., with medical support in community.

If you are referring to the **Program for Traumatic Stress Recovery**, please indicate the type of trauma the patient experienced: □ Childhood □ Adult domestic □ Occupational □ Accident-related □ Other: _____
Please list patient's current trauma-related symptoms:

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Patient Name: _____

PLANNING FOR FOLLOW-UP

Does the patient have an address to return to? □ No □ Yes		
Name of patient's Family Physician (if not listed above):		
Address:		
City:	Province/State:	Postal/Zip Code:
Country:	E-mail Address:	
Telephone:	Fax:	
Length of time providing care for this individual:		
Will the above Family Physician be providing follow-up care? □ Yes □ If No, please provide contact information for the Physician providing follow-up care, including **name**, **address**, **phone number, fax number** and **email address**:		

ALTERNATE FOLLOW-UP CONTACT INFORMATION

Name:		
Role: □ Psychiatrist □ Therapist □ EFAP □ Case Manager □ Social Worker □ Nurse Practitioner □ Health Authority □ Other: _____		
Address:		
City:	Province/State:	Postal/Zip Code:
Country:	E-mail Address:	
Telephone:	Fax:	
Length of time providing care for this individual:		

Additional comments (i.e., your goals/your patient's goals for this admission):

How did you hear about Homewood?
□ Patient request □ Past referral □ Social Media □ Conference □ Brochure □ Direct Mail Package
□ Health Professional □ Website □ Other

Thank you for your referral to Homewood Health Centre. In order to confirm this referral, please advise your patient to complete and submit the **Patient Information Form** (available online at www.homewoodhealth.com).

All forms and copies of past records and reports should be sent as soon as possible to:
Admission Department, Homewood Health Centre
150 Delhi Street, Guelph ON N1E 6K9
PH: 519.767.3550 • T/F: 866.839.2594 • FX: 519.767.3533 • EM : admit@homewoodhealth.com

We will contact you once a decision has been made regarding your patient's admission. If you have any questions, please contact our Admitting Office at 519.767.3550. We are available Monday through Friday (excluding holidays) from 8:30 AM to 9:00 PM EST.