

Date of Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral Form for Admission to Homewood Health Centre**

**Patient Information**

|  |  |  |
| --- | --- | --- |
| Patient Name: |  | |
| Address: |  | |
| City: | Province/State: | Postal/Zip Code: |
| Country: | Email Address: | |
| Telephone: | Business/Mobile Phone: | |
| Date of Birth (YYYY-MM-DD): |  | Gender: |
| Health Card Number: |  | |
| Version Code: | Expiry Date: | |
| Department of National Defense Blue Cross Service # (if applicable): | | |
| Veterans Affairs Canada K # (if applicable): | | |

**Referring Clinician Information**

|  |  |  |
| --- | --- | --- |
| Your Name: |  | |
| Your Health Care Discipline e.g. Family Medicine, Social Worker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Address: |  | |
| City: | Province/State: | Postal/Zip Code: |
| Country: | Email Address: | |
| Telephone: | Fax: | |
| OHIP Billing # (if referred by an Ontario Physician or Nurse Practitioner): | | |
| Are you referring as part of: | WSIB  DND  VA  Other Agency: | |
| No  Yes Will you provide this patient care after discharge? If not, who will: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

*In order to arrange a timely admission to the most appropriate program, please provide us with clinical information, dating back at least 2 years. Copies of past consults, test results and discharge summaries are very helpful.*

**Primary Reason for Referral:**

|  |
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| **BC Referrers Only**: Please indicate if referring to Whole Recovery Assistance Program (WRAP) AMS ☐ AMS-PTSR☐ |

Please check all the problems your patient has and star your primary concern:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| In the last 6 months | Prior to 6 months ago |  | In the last 6 months | Prior to 6 months ago |  |
|  |  | Eating Disorder |  |  | Suicide Attempts |
|  |  | Substance Abuse (drug and/or alcohol) |  |  | Schizophrenia |
|  |  | Addiction (drug and/or alcohol) |  |  | Bipolar Disorder |
|  |  | Chronic Pain |  |  | Major Depression |
|  |  | History of Abuse or Trauma |  |  | Hypomania |
|  |  | PTSD (post-traumatic stress disorder) |  |  | Mania |
|  |  | Self-Harm (e.g. cutting, burning self) |  |  | Violence |
|  |  | Personality Disorder |  |  | Aggression |
|  |  | Dementia |  |  | ADHD |
|  |  | Social Phobia |  |  | Flashbacks |
|  |  | Panic Disorder |  |  | Nightmares |
|  |  | OCD (Obsessive Compulsive Disorder) |  |  | Dissociation |
|  |  | Multiple Personality (D.I.D) |  |  | Acute Psychosis  (thought disorder/hallucination/delusion) |
|  |  | Cognitive Disorder  (head injury, memory problems) |  |  | Chronic Psychosis (thought disorder/hallucination/delusion) |

**Section 1: Current Safety Risks (Check all that Apply)**

|  |  |
| --- | --- |
| Wandering / AWOL Risk | Risk of Falling, History of Recent Falls |
| History of Violence Towards Self (self-harm) | Current Thoughts of Harm to Others |
| Current Passive Suicidal Thoughts | History of Violence Toward Others or Property |
| Current Active Suicidal Thoughts | History of Fire Setting |
| History of Suicide Attempts, Date of Last Suicide Attempt: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Please provide additional details regarding risks identified above: | |

**Section 2: Recent Admissions**

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| Has the patient had any psychiatric and/or medical hospitalizations within the last 5 years?  Yes  No If yes, where, when and why?  ***Please forward discharge notes or consults from hospital stays*** |
| Yes  No Is the patient currently in a hospital? If Yes, Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Admission date there: |
| Yes  No Is their current status involuntary? (certified inpatient) |

**Group Ready**

|  |  |  |
| --- | --- | --- |
| No | Yes | Is the patient able to participate in a group based program? |
| No | Yes | 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)? |

**Section 3: Current** Medications (psychiatric and other, e.g. insulin. Please list here or attach a list)

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Dosage | Frequency | Reason for Use |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Yes  No Do they take prescribed opiates? (E.g. codeine, Methadone etc.) If yes,  for pain,  for addiction. | | | |

|  |  |  |
| --- | --- | --- |
| Current Height: | Current Weight: | |
| Please indicate if the patient has tested positive for:  C-Difficile  MRSA  VRE | | |
| **Section 4: Addiction** | | |
| Yes  No Does the patient currently have any drug or alcohol (substance) problems? If no, go to Section 5 | | |
| If yes, their #1 substance of choice is: | | |
| Years of use: | | Amount used per day: |
| If yes, their #2 substance of choice is: | | |
| Years of use: | | Amount used per day: |
| Yes  No Has the patient ever experienced severe withdrawal symptoms from alcohol or drugs (e.g., DTs, psychosis, seizures or hallucinations)? If yes, describe: | | |
| No  Yes Does the patient admit to having a drug or alcohol problem? | | |
| **Methadone or Suboxone Use (note: some programs have specific admissions requirements concerning Methadone treatment.)** | | |
| Is the patient currently prescribed Methadone?  Yes, Dosage\_\_\_\_\_\_\_ mg/day  No. Suboxone?  Yes  No | | |
| This is for  addiction treatment  chronic pain management | | |
| No  Yes Is the patient willing to taper off Methadone or Suboxone, if necessary? | | |
| Yes  No Is the patient using medical marijuana? | | |

**Section 5**

|  |
| --- |
| If you are referring to the **Eating Disorders Program** additional information will be needed. Forms will be forwarded to the patient. |
| If you are referring to the **Program for Traumatic Stress Recovery**, please indicate all the types of trauma the patient has experienced:  Violence  Accident  Occupational  Military  Childhood Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Who will provide care post-discharge from Homewood?**

|  |  |  |
| --- | --- | --- |
| Name: | | |
| Health Care Discipline: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Address: | | |
| City: | Province/State: | Postal/Zip Code: |
| Country: | Email Address: | |
| Telephone: | Fax: | |

Thank you for your referral to Homewood Health Centre. Please advise your patient to complete and submit the Patient Information Form (available online at [www.homewoodhealth.com](http://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: 519.767-3350 ● T/F: 866.839.2594 ● FX: 519.767.3533 ● EM: [admit@homewoodhealth.com](mailto: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.