Canadian Mental Health Association
Simcoe County
Gambling, Substance Use and Mental Health Services

Case Management Referral Form

Case management, as provided by the Canadian Mental Health Association – Simcoe County Branch, is a ***voluntary*** service available to individuals that have a ***severe and persistent*** mental illness that seriously impairs or limits their ability to function in major life activities. These life activities may include activities of daily living such as eating, bathing and dressing; maintaining a household; managing money; appropriate use of medication; functioning in social, family or vocational contexts. Case management eligible diagnoses include schizophrenia or another psychotic disorder; bipolar disorder; severe personality disorder; or a serious mental illness complicated by substance use.

Case management is an action-based, goal-oriented service wherein support is provided to individuals that are seeking to make changes, and work toward setting and achieving goals, in areas that they are having difficulty due to their mental health condition(s). Case management's core values include a focus on client centered service, building client resiliency, and promoting independence.

NOTE:

- Psychiatric consultation services are available through the Ontario Telemedicine Network and require a referral from a physician/nurse practitioner. Case management services do not have access to a psychiatrist.
- Counselling and therapy services are offered by other agencies in the community, including Catholic Family Services of Simcoe County and the Barrie and Community Family Health Team (BCFHT)'s Mental Health Team (a referral is needed from a physician that is a member of the BCFHT). Other more specialized counseling may be offered by other community agencies.
- Individuals seeking support finding and securing housing can be directed to Empower Simcoe's Housing First program and/or the David Busby Street Centre

Referral Criteria (* includes required criterion):

1. Age 16+* ☐ Yes ☐ No

2. Diagnosis of severe and persistent mental illness* ☐ Yes ☐ No
   Examples: bipolar disorder, schizophrenia, schizoaffective disorder, mood disorders, **severe** personality disorder, serious mental illness complicated by substance use

3. The applicant ***is willing*** to participate in case management services* ☐ Yes ☐ No

4. The applicant ***must live within our catchment***, and be able to attend services within the City of Barrie or Town of Innisfil limits ☐ Yes ☐ No

Please note that this referral is not a guarantee of the applicant being accepted for case management supports. Within five business days of receiving this referral, a member of our Central Intake team will be in contact with the applicant to complete further screening to determine the applicant's eligibility to be scheduled for an intake interview.

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WELCOME!

Please ensure that you have completed the accompanying screening tool to ensure that the applicant qualifies for this service.

We want to process this application as quickly as possible. In order for us to do so, please also answer as many questions as you can in each of the following sections and include as many of the additional support documents as possible requested on the last page.

Please **PRINT** all answers in ink. Should you have any questions or require assistance with filling in this form, please contact the Central Intake team, and we will be happy to assist you further.

Mail, fax or email the completed application form to the address and fax number below.

Central Intake
128 Anne St. South
Barrie, Ontario
L4N 6A2
Phone: (705) 726-5033 ext. 478 Fax: (705) 797-2035
Email: centralintake@cmhastarttalking.ca

A/ PERSONAL AND CONTACT INFORMATION

Person Being Referred:

First Name: _____ Last Name: _____

Current address: _____

Apt. No.: _____ Buzzer/Entry code: _____

City: _____ Province: _____ Postal code: _____

Preferred Method of Contact: ☐ Telephone ☐ Email ☐ Text Message

Contact Information: _____

Calls from CMHA – Simcoe County are received from a private/unknown number. Can the applicant accept calls from a private/unknown caller? ☐ Yes ☐ No

Can a message be left at the phone number provided? ☐ Yes ☐ No

Date of Birth: (mm/dd/yy) _____

Does the applicant have an Ontario Health Card: ☐ Yes ☐ No ☐ Don't know

Ontario Health Card Number (if known): _____ **Version Code:** _____

Does the applicant speak English: ☐ Yes ☐ No ☐ Some

What is the applicant's first language(s): ☐ English ☐ French ☐ Other _____

What is the applicant's preferred language: ☐ English ☐ French ☐ Other _____

What is the applicant's ethnicity and/or culture (*i.e.* what culture or ethnicity do they identify with)?

Culture/Ethnicity: _____ Citizenship/Immigration status: _____

B/ REFERRAL SOURCE INFORMATION *(Please complete if not a self-referral)*

Referrer's name & Title: _____Agency:_____

Telephone # _____ Fax# _____

Street Address: _____ Apt./Suite No.: _____

City: _____ Province: _____ Postal code: _____

Relationship to Applicant:_____

C/ HEALTH INFORMATION

How long has the applicant been experiencing mental health difficulties (*i.e.* length of time)?

_____

What is the applicant's mental health diagnosis? Please be as specific and detailed as possible.

_____
_____
_____
_____
_____
_____
_____

What was the age of onset of this diagnosis? _____

Is the applicant currently on a Community Treatment Order (CTO)? ☐ Yes ☐ No

Does the applicant have a psychiatrist? ☐ Yes ☐ No

If yes, please provide the following information on the psychiatrist:

Name:_____ Telephone #:_____

Does the applicant have a primary care provider? (*e.g.* Family doctor, nurse practitioner)? ☐ Yes ☐ No

If yes, please provide the following information on the primary care provider:

Name:_____ Telephone #:_____

D/ SUPPORT NEEDS

Applicant is requesting support with:

☐ Managing specific symptoms of serious mental health illness
☐ Finances
☐ Peer supports
☐ Substance abuse/addictions issues
☐ Social engagement
☐ Other:_____

☐ Developing daily living skills
☐ Educational opportunities
☐ Occupational/Employment/Vocation
☐ Relationships
☐ Maintaining housing

_____
_____

Referral source comments regarding the applicant's support needs:

Please briefly describe the reason(s) for referral. What is the present difficulty and in which areas could the applicant benefit from support?

_____
_____
_____
_____

E/ SUPPORTING DOCUMENTATION

In order for us to process this referral within 30 days, it is essential that we receive as much of the following documentation as is available to you:

- ☐ Hospital Discharge Summaries (complete history as available)
- ☐ Hospital Documentation (from last 3 months only)
  - Case reviews
  - Nursing notes
  - Treatment plan(s)
- ☐ Specialty and/or specialist assessments (complete history as available)
- ☐ CTOs (Community Treatment Orders)

F/ APPLICANT AND REFERRER'S DELCARATION AND CONSENT

Signed and valid consent forms allowing communication between the referral source and the Canadian Mental Health Association – Simcoe County Branch ? ☐ Yes ☐ No

I have discussed this referral with the applicant and the applicant agrees with the submission of this referral.

Referrer's signature: _____ Date: _____

***Applicant's signature: _____ Date: _____**
-Applicant's signature is preferred, but not necessary if being referred by a third party