ST. JOSEPH'S CARE GROUP

Referral For Thunder Bay Mental Health Programs

Regional Health

Client Name ______________________ Referral Date (dd/mm/yy)______________

Date of Birth (dd/mm/yy)__________ Sex: Male ☐ Female ☐ Family Physician______________________

Address ______________________________________ Telephone (h)__________ (w)__________

OHIP # __________________________ WSIB # ______________________________

Mental Health Issues

Mood Disorders
- ☐ Depressed Mood
- ☐ Elevated Mood
- ☐ Suicidal Thoughts/Actions/Behaviours
- ☐ Fluctuating Mood (Mood Swings)
- ☐ Self Harm

OTHER ISSUES
- ☐ Sexual/Gender Identity
- ☐ Self Esteem
- ☐ Anger/Temper Control
- ☐ Eating Disorders

(If primary issue, please refer to Eating Disorders Program)
- ☐ Post Partum Disorder

Psychosocial Issues

Family/Relationship Issues
- ☐ Marital/Partner Problem
- ☐ Separation/Divorce
- ☐ Sexual Problem
- ☐ Parenting Issues
- ☐ Children at Risk
- ☐ Custody/Access
- ☐ Illness in Family Member
- ☐ Other Family Problems
- ☐ Other Relationship Issues
- ☐ Lack of Social Support/ Isolation

Anxiety Disorders
- ☐ Obsessive Thoughts
- ☐ Compulsive Behaviour
- ☐ Phobia(s)
- ☐ Panic Symptoms or Attacks
- ☐ Other Anxiety Symptoms
- ☐ Post Traumatic Stress Disorder

Psychotic Disorders
- ☐ Delusions
- ☐ Hallucinations
- ☐ Disorganized Thought Processes

Abuse Issues
- ☐ Current Physical/Sexual/Emotional Abuse
- ☐ Past Physical/Sexual/Emotional Abuse

Addictions
- ☐ Recent Alcohol/Drug Abuse/Self
- ☐ Past Alcohol Abuse/Self
- ☐ Alcohol/Drug Abuse/Family Member
- ☐ Problem Gambling
- ☐ Gambling/Family Member

Neurological Symptoms
- ☐ Memory Impairment
- ☐ Confusion
- ☐ Attention Deficit/Hyperactivity
- ☐ Developmental Disability
- ☐ Brain Injury

Socioeconomic Issues
- ☐ Problems at Work
- ☐ Problems at School
- ☐ Unemployment
- ☐ Homelessness
- ☐ Financial Issues
- ☐ Legal Issues
- ☐ Difficulty with Access to Disability Benefits:
  - ☐ CPP ☐ LTD
  - ☐ ODSP ☐ WSIB
  - ☐ Auto Insurance

Grief/Bereavement/Spiritual Issues:
- ☐ Death
- ☐ Other Loss
- ☐ Loss of Meaning and Purpose
- ☐ Relationship with God

SPECIAL NEEDS:

(interpreter, physical access, visual impairment, deaf, etc.) ________________________________

Medical/Physical Issues
- ☐ Chronic Pain
- ☐ Headache
- ☐ Physical Disabilities
- ☐ Chronic Illness______________
- ☐ Difficulty coping with chronic illness/self
- ☐ Difficulty coping with chronic illness/family
- ☐ Medication Issues ______________
- ☐ Pregnancy

Other ______________________

Current Medications	Dosage	Date Started

Criteria for Prioritizing and Risk Assessment:

1. **Check the statement that best applies:**
   - ☐ No suicidal thoughts
   - ☐ Only fleeting suicidal thoughts
   - ☐ Suicidal thoughts with no plan
   - ☐ Has current/imminent intent to suicide
   - ☐ Has had a recent suicide attempt
2. **Has the client been using crisis response, the emergency department, or mental health hospitalization in the last 12 months?**
   - ☐ Yes ____ (number of times)
   - ☐ No
3. **Does the client have a chronic history of mental health problems?**
   - ☐ Yes
   - ☐ No
4. **To what degree is client's daily functioning impaired by mental health issues:**
   - ☐ Mild impairment
     (eg. Falling behind, temporary/expected social difficulties or transient and/or expectable psychological reactions)
   - ☐ Moderate impairment
     (eg. Some ongoing difficulties, few friends, some ongoing conflicts or occasional psychological symptoms or flat affect)
   - ☐ Severe impairment
     (eg. Unable to work, cannot keep a job, failing school, no friends, neglects family, severe/persistent psychological or suicidal ideations)
5. **Has client experienced a significant trauma within the last 6 months?**
   - ☐ Yes
   - ☐ No
6. **Any concerns around pregnancy or post partum issues?**
   - ☐ Yes
   - ☐ No
7. **Does client have any psychotic symptoms?**
   - ☐ Yes
   - ☐ No
8. **Is client presently homeless or at risk for homelessness?**
   - ☐ Yes
   - ☐ No

Interventions Requested

(check only those that apply)

- ☐ diagnostic clarification
- ☐ medication consultations
- ☐ counselling / psychotherapy
- ☐ psycho-educational groups

Additional Comments:

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Referrent/Physician/Agency______________________________ Signature______________________________

(Please print clearly)

Address ____

Please return referral form with any additional information attached to:

Community Mental Health Services

St. Joseph's Health Centre

710 Victoria Ave E., Thunder Bay, ON P7C 5P7

Fax: 624-3523