Canadian Mental Health Association
Thunder Bay
Mental health for all

First Place
Clinic & Regional Resource Centre

First Place
Referral Package

SERVICE OVERVIEW:
First Place, Clinic and Regional Resource Center is a specialized service that offers community based consultation and treatment for individuals who are experiencing a first episode of psychosis. The important role of families, significant others and community resources is significant in recovery and therefore active involvement of key supports is encouraged. The ultimate goal of the service is to facilitate early identification of psychosis and to facilitate optimal treatment interventions that lead to the maintenance of meaningful functional recovery from psychosis. An interdisciplinary team approach is applied in all aspects of care and includes disciplines such as psychiatry, nursing, social work, psychology, and rehabilitation specialties.

REGIONAL OUTREACH:
First Place, Clinic and Regional Resource Center accepts referrals from the following areas: Thunder Bay City, Thunder Bay District and Kenora/Rainy River District.

Services are offered via face to face visits at the Center, via telephone and/or videoconferencing and through the implementation of a regional outreach strategy. A regional travel schedule is established to facilitate visibility in the region for the purpose of referral, treatment planning, community engagement and education and networking.

Because it is important to ensure that support is available to individuals as close to their home as possible the Centre must rely on a shared care approach especially in the region. Formal and informal collaboration and service planning with key community service providers is therefore an integral component of the regional travel schedule.

Please call First Place for information about when the service team may be in your area.

REFERRAL PROCESS:

Please contact First Place directly should you want to clarify referral criteria and processes before initiating a referral.

This referral form collects clinically relevant information to aid our screening and assessment process. *Please complete the form in its entirety and forward to us any other relevant clinical information, including any assessments, consultations, psychiatric admissions, ER notes, neuropsychological testing, and rehabilitation reports*. The information collected is confidential. We will protect the information in a manner consistent with the Personal Health Information Protection Act, 2004.

With client consent, please email, fax or mail completed referral form to:

First Place at 807.345.0030 or firstplace@cmha-tb.on.ca

Eligibility criteria for First Place (Ministry Specified Guidelines):

1. 14 to 35 years of age
2. First episode of psychosis
3. No treatment history for psychotic illness *or* began treatment within the last year only
4. Willing and able to access community based treatment services for psychosis
5. Absence of organic brain disorder/impairment

* Once a referral is screened and accepted, we offer an initial consultation assessment. We use this process to determine intervention needs and whether continued involvement with First Place would be most appropriate.

NON-PHYSICIAN REFERRALS: Please ensure that over-seeing physicians are made aware of the referral to First Place. If someone is currently under the care of a psychiatrist, we require that he/she is consulted and in agreement with the referral.

FIRST PLACE
CLINIC & REGIONAL RESOURCE CENTRE
T: 807.345.0060 F: 807.345.0030 firstplace@cmha-tb.on.ca

Referral Form

[Fax completed form to: 807-345-0030]

REFERRAL SOURCE INFORMATION

❒ General Practitioner or Family Physician
❒ Psychiatrist (In or Outpatient care)
❒ Hospital Emergency Department
❒ Other Hospital Based / Health Service Provider
❒ Community Based Service Provider
❒ Family
❒ Other: _____

Name: _____ Billing #: _____

Address: _____ City & Postal Code: _____

Phone: _____ Fax Number: _____

Email: _____

Is this your first time making a referral to First Place? ❒Yes ❒No Organization: _____

CLIENT INFORMATION:

Name (First-Middle-Last): _____

Alias: _____ Gender: ❒M ❒F

Date of Birth (DD/Month/YYYY): _____ Current Age (yrs): _____

Is the client of self-identified Aboriginal status? ❒Yes ❒No ❒Unknown Status #: _____

Preferred Language: ❒English ❒French ❒Ojibway ❒Other: _____ Marital status: _____

Address: _____ City & Postal code: _____

Home Phone: _____ OK to leave message? ❒ Yes ❒ No

Alternate Phone: _____ OK to leave message? ❒ Yes ❒ No

HIN (OHIP) #: _____ Version Code: _____ Expiry Date: _____

Does client consent to this referral? ❒ Yes ❒ No, if no explain _____

GUARDIAN/PRIMARY FAMILY CONTACT INFORMATION

Name: _____ Relationship: _____

Contact info (if different from client): _____

Does client consent to First Place contacting this person? ❒ Yes ❒ No if No, explain _____

Next of kin if different that above: _____

Does client consent to First Place contacting this person? ❒ Yes ❒ No if No, explain _____

Emergency Contact: _____

Does client consent to First Place contacting this person? ❒ Yes ❒ No if No, explain _____

LIVING SITUATION/EDUCATION HISTORY

Who does the client live with? _____

Currently enrolled in school? ❒ Yes ❒ No ❒ Unknown/Client declined to answer

If yes, what school? _____ Grade or Program completed: _____

PRIMARY CARE PROVIDER

Does the client have a family physician or nurse practitioner? ❒Yes ❒No ❒ Same as Referral Source

Name: _____ Billing #: _____

Address: _____ City: _____ Postal Code: _____

Phone: _____ Fax Number: _____

PRESENTING ISSUES

Is the client experiencing any of the following symptoms of psychosis? (Check all that apply)

- ❒ Hallucinations
- ❒ Delusions
- ❒ Confused thinking
- ❒ Mood changes
- ❒ Behavior changes
- ❒ Changes in eating or sleeping patterns
- ❒ Cognitive changes
- ❒ Paranoia

Please describe the psychosis in further detail.

When was the age of onset of the above symptoms? _____

How many years of treatment for psychosis has the client had? _____

Do you have concerns about the client's use of any substances?

❒ Yes ❒ No ❒ Unknown If yes, please specify:

Current	Past	Current	Past
❒	❒ Alcohol	❒	❒ Solvents
❒	❒ Marijuana	❒	❒ Caffeine
❒	❒ Cocaine/Crack	❒	❒ Over the counter drugs
❒	❒ Ecstasy	❒	❒ Injection drug use
❒	❒ Prescription drugs	❒	❒ Other:

Does the client experience suicidal ideation?
❒ Yes ❒ No ❒ Unknown/client declined to answer
If yes, explain

Does the client experience homicidal ideation?
❒ Yes ❒ No ❒ Unknown/client declined to answer
If yes, explain

Does the client currently experience aggression/violent tendencies?
❒ Yes ❒ No ❒ past history of aggression/violence ❒ Unknown/client declined to answer
If yes, explain

Please describe any other present mental health concerns, difficulties, housing etc.

CLIENT NAME:
DOB:

EMPLOYMENT/LEGAL HISTORY

Employment: _____

Source of Income: _____

Legal system involvement? *Current* ❒ Yes ❒ No ❒ Unknown/Client declined to answer

If yes, please explain: _____

Legal system involvement? *Past* ❒ Yes ❒ No ❒ Unknown/Client declined to answer

If yes, please explain: _____

PSYCHIATRIC HOSPITALIZATION HISTORY

❒ No hospitalizations or treatment ❒ Unknown/client declined to answer

Is the client currently in the hospital? ❒ Yes ❒ No Date of discharge: _____

Age of first psychiatric hospitalization: _____

Please list current and/or previous mental health treatment history (including hospitalizations with length of stay in and date of involvement).

MEDICAL INFORMATION

Please list all medications, herbal remedies, methadone treatment, etc.

Medication	Dosage	Start date (month, year)

Is the person taking the medication(s) regularly? ❒ Yes ❒ No ❒ Stopped taking ❒ Unknown

If no or stopped taking, please explain:

Do you have any allergies:
If yes, please list:

MEDICAL CONDITIONS

Please review this list and check those conditions that have affected your health recently or in the past. Check conditions that apply:

❒ arthritis	❒ hepatitis (A, B, C, other)	❒ heart conditions	❒ diabetes
❒ skin conditions	❒ back problems	❒ blood clots	❒ stroke
❒ high blood pressure	❒ broken/dislocated bones	❒ surgery	❒ insomnia
❒ bruise easily	❒ TMJ disorder	❒ muscle strain/sprain	❒ scoliosis
❒ cancer	❒ pregnancy	❒ chronic pain	❒ constipation/diarrhea
❒ diverticulitis	❒ seizures	❒ headaches	❒ whiplash
❒ depression, panic disorder, anxiety		❒ auto-immune condition (AIDS, fibromyalgia, chronic fatigue, lupus etc.)	

If any of the above needs to be detailed or if there is anything else to share, please do so:

CLIENT NAME:
DOB:

OTHER INFORMATION

Does the client have a developmental disability (e.g. Down Syndrome, Autism) or intellectual deficits?

❒ Yes ❒ No ❒ Unknown/Client declined to answer

If Yes, Please specify: _____

Does the client have an organic brain disorder or acquired brain injury?

❒ Yes ❒ No ❒ Unknown/Client declined to answer

If Yes, Please specify: _____

Does the client have a primary diagnosis of a personality disorder? (e.g. Borderline Personality Disorder, Antisocial Personality Disorder, Dependent Personality Disorder, etc.)

❒ Yes ❒ No ❒ Unknown/Client declined to answer

If Yes, Please specify: _____

Does the client need specialized services? (e.g. interpretation, wheelchair access, attendant care)

❒ Yes ❒ No ❒ Unknown/Client declined to answer

If Yes, Please specify: _____

Any further comments:

Does the client consent to this referral to First Place? ❒ Yes ❒ No

If no, explain _____

_____ _____

Signature (client) mm/dd/yyyy

_____ _____

Signature (referral source) mm/dd/yyyy

Prior to submitting this referral please confirm that a billing # has added for both the referral source and primary care provider.

Thank you

CLIENT NAME:
DOB: