Canadian Mental Health Association Thunder Bay
Mental health for all

Association canadienne pour la santé mentale Thunder Bay
La santé mentale pour tous

First Place Clinic and Regional Resource Centre

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 using the NAVIGATE model of care which is evidenced based and leads 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 consulting psychiatry, nursing, social work, psychology, and rehabilitation specialties.

Eligibility criteria for First Place (Ministry Specified Guidelines):

- 14 to 35 years of age (Individual case review for referrals whose age is outside of this range)
- First episode of psychosis
- No treatment history for psychotic illness or began treatment within the last year only
- Willing and able to access community based treatment services for psychosis
- Absence of organic brain disorder/impairment

Referrals:

First Place Clinic and Regional Resource Centre accepts referrals from all communities in Northwestern Ontario.

Referral Process:

Please contact First Place Clinic and Regional Resource Centre directly should you want to clarify referral criteria and processes before initiating a referral at: (807) 345-0060; Hours of Operation: Monday through Friday from 9:00 a.m. to 5:00 p.m.

The 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 completed, referral form can be emailed, faxed or mailed to First Place Clinic at:
Fax: 807-345-0030; firstplaceadmin@cmha-tb.on.ca or First Place Clinic and Regional Resource Centre, 28 N. Cumberland Street, 5th Floor, Thunder Bay, ON P7A 4K9.

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 Clinic would be most appropriate.

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First Place Clinic and Regional Resource Centre
Referral Form

Send completed form to: 807-345-0030 (fax), or firstplaceadmin@cmha-tb.on.ca

(*Required)

Section 1: Referral Source Information

This referral is being completed by:

☐ General Practitioner or Family ☐ Self-referral ☐ Family member/Friend

☐ Physician or Psychiatrist ☐ Hospital / ER Dept ☐ Community Based Service Provider

☐ Other Health Service Provider ☐ Other:

*Referral Source Name: _____ *Referral Source Fax: _____

*Referral Source Phone: _____ *Referral Source Email: _____

Section 2: *Required Client Documentation (please include the following with referral)

- Laboratory & Diagnostic Reports (for example CBC, Metabolic Labs, ECG, MRI)
- Discharge Summary Profile and Plan
- MAR Sheet

> Failure to include relevant information and documents with this referral will delay the referral process.
> This information is only not required if being submitted by non-medical team (i.e. self-referral)

Section 3: Eligibility Criteria

- Person is between the ages of 14 and 35 years of age
- Person has experienced recent symptoms of a first episode of psychosis for less than one year
- Has received treatment for psychosis for 1 year or less; or has had no treatment
- Symptoms of psychosis is the primary issue or concern
- Person is aware the referral is being made for them
- Person has an absence of organic brain disorder/impairment

Section 4: Client Information

*Name (First Middle Last): _____ Gender: ☐ Male ☐ Female ☐ Other:_____

Preferred language: _____ *Date of birth (DD/MM/YYYY): ___/___/____ Current age (years): _____

Does client self-identify with BIPOC (Black, Indigenous, or People of Colour): ☐ Yes ☐ No ☐ Unknown

Address: _____ City: _____ Postal Code: _____

*Phone: _____ Ok to leave message? ☐ Yes ☐ No

Alt phone: _____ Ok to leave message? ☐ Yes ☐ No

HIN (OHIP)/Insurer# _____ Version Code: _____ Expiry Date (DD/MM/YYYY): ___/___/____

Email: _____ Does client consent to this referral ☐ Yes ☐ No - If no, explain: _____

Section 5: Guardian / Primary Family Contact Information

Name: _____ Relationship: _____

Phone: _____ Alternate phone: _____ Email: _____

Does client consent to First Place Clinic contacting this person? ☐ Yes ☐ No (If no, explain):_____

Who does the client live with? _____

Section 6: Education / Work / Legal

Currently enrolled in school? ☐ Yes (if yes, which school?)_____ ☐ No ☐ Unknown

Currently employed? ☐ Yes working part-time ☐ Yes working full-time ☐ Not employed ☐ Unknown

Section 7: Primary Care Provider

Does the client have a family physician, Nurse Practitioner, or attend a Community Based Health Centre? ☐ Yes ☐ No ☐ Same as referral source

Name: _____ Address: _____ City: _____

Postal code: _____ Phone: _____ Fax: _____

Section 8: Presenting Issues

*Examples/explanations are required

Hallucination symptoms: _____

Delusion symptoms: _____

Confused thinking: _____

Mood changes: _____

Behavioural changes: _____

Changes in eating or sleeping patterns: _____

Cognitive changes: _____

Paranoia: _____

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

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

Any concerns about the client's use of any substances? ☐ Yes (if yes, please specify below) ☐ No ☐ Unknown

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

Section 9: Hospitalization History

Hospitalizations or treatment? ☐ No ☐ Unknown/Declined to answer

Is the client currently in the hospital ☐ No ☐ Yes (if yes, date of discharge): _____

Section 10: Risk Assessment

Risk to self? ☐ No ☐ Historically ☐ Current
Please provide details:

Risk to others or from others? ☐ No ☐ Historically ☐ Current
Please provide details:

Does the client have a history of, or current involvement with the law/court system? ☐ Yes ☐ No ☐ Unknown / Declined to answer

Please list historical/current/pending legal charges:

Does this person have capacity of decision making regarding treatment ☐ Yes ☐ No

If no, who is the substitute decision maker? _____

Does this person have a CTO: ☐ Yes ☐ No ☐ Considering