London Health Sciences Centre

Children's Hospital
London Health Sciences Centre

Family Referral Guidelines & Eligibility – Transcultural Mental Health

1. Referrals are open to individuals identifying as **immigrant or refugee**, across the lifespan (childhood to adulthood), who are experiencing persistent or acute presentation of **moderate to severe** mental health concerns, which are influenced by a **cultural component**.

   For the purpose of screening, moderate to severe mental health concerns will be identified in the following pages through a series of questions focused on the individual's ability to function in various areas of life, risk factors, and current presentation of illness

   Referred individuals may have experienced: war and/or migration trauma, family separation and reunification related to the migration process, post migration adjustment concerns, or be unaccompanied youth/ young adults

2. We offer a collaborative care model which requires partnership in the process. To be eligible for service the individual listed as the referral source will be involved throughout the consultation process, which may include attendance at certain client appointments or phone consultations with the team. The referral source is a professional already connected to the client (i.e. Settlement Counsellor, Social Worker, Mental Health Case Manager, etc.).

3. Please contact the team at 519-685-8500 ext. 74812, if there are concerns regarding health care coverage.

If the client is actively planning suicide or presents with immediate risk to self or others, the client should be directed to the Emergency Department at Victoria Hospital for assessment. If they don't need urgent medical attention but are still in crisis, consider visiting the CMHA Crisis Centre or calling the Crisis Intake Team instead of going to the Emergency Department.

For clients over the age of 16, the CMHA Crisis Centre is located at 648 Huron St., 519-434-9191 (business hours) or call London District Distress Centre 519-433-2023 (24 hour number).

If under the age of 16, call the Vanier, Craigwood and WAYS - Crisis Intake Team at 519-433-0334.

Referral Source Information (to be filled out by referral source)

Referral Source Agency: _____

Name of Referral Source: _____

Phone Number: _____

Primary Case Manager (if different from above): _____

Resources currently involved in the community (please provide agency names or contacts if available):

- ☐ Settlement Services (SWIS Worker, Settlement Counsellor, Case Manager)
- ☐ Counselling Services
- ☐ School Support Services (Social Work, ESL, Learning Resources)
- ☐ Hospital Services (Inpatient MH, Outpatient MH)
- ☐ Child Welfare
- ☐ Legal Services
- ☐ Other _____

The personal information on this form is collected under the authority of the Health Protection and Promotion Act and applicable privacy legislation. This information will be used to refer the client to this specialized mental health service. We will keep this information private. Any questions about the collection of this information should be directed to the Program Development Facilitator at 519-685-8500 ext. 74812.

☐ **Reviewed with client by referral source**

Personal Information of Family Contact (to be filled out by client, potentially with referral source support)

Full Name: _____ Gender: ☐ M ☐ F ☐ Other
Last First

Address: _____
Street Address Apartment / Unit #

Phone: _____ Can we leave a message? ☐ Yes ☐ No

Date of Birth: _____ OHIP # with VC: _____ OHIP expiry date: _____
YYYY/MM/DD YYYY/MM/DD

Emergency Contact & Relationship: _____ Phone Number: _____

Marital Status: _____ Number of children Living in the home: _____

Interim Federal Health (if applicable): _____

Primary Care (GP, NP): _____ Phone Number: _____

Pharmacy: _____ Phone Number: _____

Ethnocultural Information

Refugee or Immigrant Status: _____ Country of Origin: _____

Date of Arrival to Canada (YYYY/MM/DD): _____ Ethnicity: _____

Religion: _____ Fluent in English: ☐ Oral ☐ Written ☐ No English

Preferred Language: _____ Fluent in: _____ ☐ Oral ☐ Written ☐ No Additional Language

Is an interpreter typically used for medical appointments?
☐ Yes ☐ No

Is an interpreter needed for this Consultation?
☐ Yes ☐ No

Name and Phone Number of Interpreter: _____

If an interpreter has not been used regularly please list reason(s):

☐ Not available ☐ Provider acted as interpreter ☐ Other: _____
☐ Not needed ☐ Family member used as interpreter _____

Presenting Concern for Consultation

Please briefly describe:

- **a)** Current situation, family members involved, symptoms being experienced;
- **b)** Areas of life most affected, length of time experienced, previous treatment interventions tried;
- **c)** Risk Factors apparent to the referral source.

Family Members Attending Consultation				
	NAME (last, first)	**ROLE** (mother, father, aunt, brother, etc.)	**HEALTH CARD NUMBER** (OHIP, IFH)	**DATE OF BIRTH** (YYYY/MM/DD)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Please send completed form to

Transcultural Mental Health Consultation Service - Fax: 519-685-8009