Children's Hospital
London Health Sciences Centre

Child and Adolescent Mental Health Care Program
Tertiary Inpatient Program Referral Package

Fax Cover Sheet

Date			**Child & Adolescent Mental Health Care Program** 800 Commissioners Rd E Zone B, 8th Floor London, Ontario N6A 4G5 **Phone:** 519-667-6640 **Fax:** 519-667-6814 **Email:** camhintake@lhsc.on.ca
To	Child & Adolescent Mental Health Care Program- Centralized Intake		
Fax #	519-667-6814		
From			
Subject	C&A Mental Health Inpatient Tertiary Care Program Referral	Total Pages:	

Referrals for inpatient admission must come from an acute care mental health unit or a coordinated access point in the patient's home community.

ABOUT OUR PROGRAM

We are a comprehensive 4–6-week program designed to support adolescents in developing essential DBT skills for effective symptom management, enhanced functioning, and healthier coping strategies throughout their recovery journey.

WHO WE SERVE

Youth facing serious mental illnesses, complicated by developmental factors and comorbidities, including; psychotic disorders, co-occurring psychiatric conditions, developmental trauma, persistent suicidality and self-harm, treatment non-adherence, functional deterioration, repeated acute care hospitalizations.

We do not provide primary treatment for substance use disorders, forensic presentation, sexual behaviour presentations, or conduct and antisocial behaviours.

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Please include the following attachments with the completed referral form

- ❑ Psychiatric assessments (Required)
- ❑ Clinical reports (Inpatient, and most recent outpatient (if applicable)) (Required)
- ❑ Crisis plan or safety plan (Required)
- ❑ Current Medication Administration Record or a list of all active prescription medications (Required)
- ❑ Current Mental Health Act forms (If applicable)
- ❑ Care Plans (if applicable)
- ❑ Psychoeducational assessments and/or Individual Education Plan (IEP) (if applicable)

Please note that transfer of accepted patients will occur dependent on bed availability during hours in which the interdisciplinary clinical team is on-site. Updated Psychiatric, Social work and behaviour reports are requested prior to scheduling admission.

At time of transfer:

- ❑ Updated Forms to include:
  - ☐ Form 50- rights advice
  - ☐ Form 10- memorandum of transfer
- ❑ Updated MAR- Medication Administration Record
- ❑ A verbal nurse to nurse handover of information at time of patient's transfer
  - ☐ Contact D4 nursing station at 519-685-8500 ext. 75875

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SECTION A – PATIENT INFORMATION						
Patient Name:						
Date of Birth: (YY/MM/DD)		**Age:**	**Health card #:**			
Address:			**City:**		**Postal Code:**	
Parent/Guardian(s):			**Relationship to Patient:**			
Phone Number(s):			**Email(s):**			
Family Physician:			**Phone Number:**			
Community Psychiatrist:			**Phone Number:**			
Other Community Supports:			**Phone Number:**			
Other Community Supports:			**Phone Number:**			
Other Community Supports:			**Phone Number:**			

SECTION B – CURRENT STATUS	
Is the patient capable of consenting to treatment? Yes ☑ No ☐	**If no, please specify SDM & Phone Number:**
Is the patient aware of and in agreement with referral for admission? Yes ☐ No ☐	**Are the patient's parent(s)/guardian(s) aware of and in agreement with referral for admission?** Yes ☑ No ☐
The parent(s)/guardian(s) are aware and in agreement with the patient attending weekend passes home as part of the treatment plan: Yes ☐ No ☐ Please provide details regarding any barriers to the patient attending weekend passes home (i.e. financial, transportation, unable to return home etc.):	
Is the patient currently in hospital? Yes ☐ No ☐	**If yes, Admission Date:**
Status: Voluntary ☐ Involuntary ☐	**Form & Expiry Date:**
Is the patient currently in a high observation/seclusion area? Yes ☐ No ☐	
Has the patient required the use of seclusion and/or restraints: Yes ☐ No ☐ If yes, please provide details:	
Is the patient currently participating in hospital/unit programming? Yes ☐ No ☐	

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Please provide details (e.g. if not, why not? If yes, are they attending groups, appropriate in group environment, participating appropriately, etc.)

If not in hospital, is the patient involved with any other community programs?

Yes ☐ No ☐

If yes, please provide details:

Patient's current residential status:

☐ Resides at home with parent(s)/guardian(s) ☐ Foster placement Other:_____

☐ Group home ☐ Kinship placement

Is the patient able to return to this living arrangement post- discharge? Yes ☐ No ☐

If no, please provide detailed plan for place of discharge upon completion of the program:

Patient's current legal status:

☐ No legal involvement ☐ Recently incarcerated ☐ Restraining order(s) present

☐ Currently on probation/parole ☐ Currently in court diversion/support program ☐ Community Treatment Order

☐ Outstanding Charges: _____

SECTION C – REASON FOR REFERRAL/REFERRAL GOALS

Please detail Physician's reason for referral (please include information on the level of severity of the mental health concerns and the effect on the patient's functioning):

Physician/Current care teams referral goals:

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Patients' referral goals:	
Parent(s)/Guardian(s) referral goals:	
SECTION D – PATIENT HISTORY	
Psychiatric Diagnoses:	
Medical Diagnoses:	
Psychosocial Stressors:	
List all prior psychiatric admissions & length of stay(s):	

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School & Grade patient attends: _____

What is the level of functioning at school: ☐ Above grade level ☐ At grade level ☐ Below grade level ☐

If the patient is below grade level, how many grades is the patient estimated to be behind? _____

Has the patient had a psychoeducational assessment completed? Yes ☐ No ☐ If yes, please include a copy with this referral package

Does the patient currently have an IEP? Yes ☐ No ☐ If yes, please include a copy with this referral package

Please provide information regarding any academic concerns the patient may have:

Does the patient struggle with social functioning? (e.g., at school, in the community, including difficulties with friendships or social skills)**:**

Yes ☑ No ☐ If yes, please provide details:

General Developmental Concerns (e.g., developmental milestones, physical difficulties, sensory issues etc.)

Has the patient had recent (within the last 6 months) suicidal ideation or had a suicide attempts? Yes ☐ No ☑ **Has the patient made any suicide attempts in their lifetime?** Yes ☐ No ☑	**If yes, please provide details:**
Has the patient recently (within the last 6 months) engaged in self-harm? Yes ☐ No ☑ **Does the patient have a history of self-harming during their lifetime?** Yes ☐ No ☑	**If yes, please provide details:**

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Has the patient recently (within the last 6 months) exhibited any externalizing and/or violent behaviours? Yes ☐ No ☑ **Does the patient have a history of violence during their lifetime?** Yes ☐ No ☑	**If yes, please provide details:**
Does the patient have a history of trauma? Yes ☐ No ☑	**If yes, please provide details:**

The undersigned have completed this to the best of their knowledge. If upon admission it is found that relevant information was omitted or falsified, the program could terminate the admission, and the referral source agrees to accept this patient back into their care immediately.

Referral form completed by: _____ **Date completed:** _____

Organization: _____ **Phone:** _____

Fax: _____ **Email:** _____

Referring Physician: _____ **Phone:** _____