ABI AND ADDICTION / MENTAL HEALTH COLLABORATIVE REFERRAL FORM

Note: Prior to completing referral, please refer to service information sheet, **For further information or help to complete this form contact:**

SEO ABI System Navigator (Providence Care Centre)
303 Bagot Street, LaSalle Mews, Suite 401
Kingston, Ontario K7K 5W7
Phone: (613) 547-6969 ext. 37165 Fax: (613) 547-6472

The **Southeastern Ontario ABI (Acquired Brain Injury) and Addiction / Mental Health Collaborative** is a group of service providers in each of the three regions of Ontario Health South East (Kingston, Frontenac, Lennox and Addington; or Hastings Prince Edward; or Lanark Leeds Grenville) who meet regularly to hear about people who meet specified criteria and are believed to be at risk. The providers talk about what services they are able to offer to address and reduce the risk.

Collaborative: ☐ Kingston, Frontenac, Lennox and Addington ☐ Hastings Price Edward ☐ Lanark Leeds Grenville

Client or Substitute Decision Maker (SDM) has provided informed consent to make referral: ☐ Yes ☐ No
(Please attach ABI and Addiction/Mental Health Collaborative signed Consent to Service form)

Client Name: _____ **Date of Birth:** _____

Address: _____

_____

Postal Code: _____ **Health Card Number:** _____

Telephone: _____ **Version Code:** _____

Living Situation: ☐ Private/ Own ☐ LTCH/ Retirement ☐ ALP/Supported ☐ Other: _____

Living Conditions: ☐ Unaffordable ☐ Neglect/ Poor Condition ☐ Inaccessible ☐ Unstable ☐ Other: _____

Reason for Referral: What are the unmet needs and risks? (refer to the definition of High Risk)
Risk factors to consider:

☐ Alcohol	☐ Mental Health	☐ Suicide	☐ Crime Victimization
☐ Sexual Violence	☐ Basic Needs	☐ Drugs	☐ Cognitive Impairment
☐ Self Harm	☐ Physical Violence	☐ Elder Abuse	☐ Missing School
☐ Poverty	☐ Gangs	☐ Gambling	☐ Physical Health
☐ Criminal Involvement	☐ Emotional Violence	☐ Supervision	☐ Negative Peers
☐ Missing/Runaway	☐ Social Environment	☐ History of Trauma	☐ Financial Vulnerability
☐ Marginalized Population	☐ Housing/Risk of LTC Admission		
☐ Antisocial/Negative Behaviour		☐ Threat to Public Health and Safety	
☐ Unemployment/Risk of losing employment		☐ Lack of History of Formal/Informal Supports	

Please provide specifics:

_____

_____

_____

High Risk definition: "individuals or families facing a number of risk factors that affect multiple areas of the individual's life and in all likelihood will lead to something bad happening and happening soon. These could include individuals that may be at risk of doing harm to others, becoming a victim, relapsing on a treatment plan, and/or ending up on the street."
Risk Level Definitions.pdf (state.or.us)

Client Surname: _____ First Name: _____ DOB (YYYY/MM/DD): _____

Self-identified gender: ☐ Gender-fluid ☐ Man ☐ Nonbinary ☐ Trans man ☐ Trans woman
☐ Two-spirit ☐ Woman ☐ Other: _____

Pronouns: ☐ He/Him ☐ They/Them ☐ She/Her ☐ Other: _____

Primary Language: ☐ English ☐ French ☐ Other: _____ Interpreter Required ☐ Yes ☐ No

Are there capacity concerns? ☐ No ☐ Yes, please explain:

Has the person been formally assessed and deemed incapable? ☐ No ☐ Yes – for ☐ Finances ☐ Personal care

Contact information for SDM (if applicable): Name: _____

Address:_____ **Telephone:**_____

What is the evidence of a known or suspected moderate to severe brain injury? E.g. GCS, PTA, Imaging, etc.

What is the evidence of a known or suspected mental health and/or substance use disorder? E.g. psychosis, mood disturbance, anxiety, etc.

Previous and Current Providers:

Funding Sources? ☐ No ☐ FT/PT Work ☐ Social Assistance ☐ WSIB/ Insurance ☐ Other: _____

Primary Care Provider: _____ Telephone: _____

Address: _____

Referred By: Name: _____

Position: _____ Agency:_____

Work Address: _____

Telephone: _____ Fax: _____

Work email: _____ Signature: _____ Date: _____