THE Access Point NORTHWEST

710 Victoria Ave. E, Thunder Bay, ON, P7E
Phone: (807) 624-3400
Fax: (807) 624-3525

Application Form

Privacy Policy

Purpose for Collection and Use of Personal Health Information (PHI)

We collect, use, and disclose PHI only for the purposes of identifying the appropriate service needs as well as:

- Collecting relevant information contained in the records maintained by the organizations associated with The Access Point Northwest.
- Making referrals to the associated agencies for services, and to fulfill other purposes required or permitted by law.
- Sending this application to any agencies that will be providing services.
- Disclosing the PHI to a person or organization other than those associated without consent in limited circumstances required by law, such as emergencies of child welfare concerns.
- Use of de-identified PHI about applicants to plan and deliver services, for program evaluation, for statistical purposes, and for reporting to our funders.

Privacy Officer

If there are any questions or concerns about privacy, please contact our Privacy Officer with The Access Point Northwest at (807)-683-8200. If there are still concerns, please contact the Office of the Information and Privacy Commissioner at 1400-2 Bloor St E, Toronto, ON M4W 1A8, (416) 326-3333.

Referral Process

Please check each of the requested services and fill out the pages for those services ***(listed in parentheses).***
To withdraw the application, please contact (807) 624-3482.

- ☐ **Case Management** (Page 1, 2, 3, and 5).
- ☐ **Supportive Housing** (Page 1, 2, 3, and 5).
- ☐ **Outpatient Mental Health** (Page 1, 2, and 3 - may be **completed only by a physician or nurse practitioner**, or with the authorization of a physician or nurse practitioner).
  - ☐ I declare that the **primary care provider** _____ is aware and in agreement with the referral.
    (Name of the PCP)

The following referrals can only be completed by the primary care provider: _____
(Billing or College Number)

- ☐ **Diagnostic Assessment or Medication Review** (Page 1, 2, 3, and 4).
  Applicants whose primary care provider is in a ***shared mental health care designated site*** *will receive psychiatric services on that site. Please contact (807) 624-3419 for further information.*
- ☐ **Chronic Pain Management** (Page 1, 2, and 6).

Declaration and Consent

☐ I have done my best to ensure that all information provided on this application is correct.
☐ I have discussed this application with the applicant and obtained the applicant's knowledge and voluntary consent to make this referral.
☐ The applicant consents to the collection, use, and disclosure of the personal health information provided.
☐ The applicant understands that the personal health information provided on this application may be shared by relevant agencies included with The Access Point Northwest.
☐ The applicant consents to The Access Point Northwest to access medical records relevant to this application.
☐ The applicant consents that if the application is not accepted, it can be forwarded to a program outside The Access Point Northwest.

Name of Referrer: full name with credentials Agency/Department: _____

Contact Number: _____ Fax Number: _____

Please attach any relevant consult letters, test results, or other pertinent medical records.

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Contact Information (paste label over top of this section)

First/Given Names(s): _____ Last Name: _____

Address: _____

Phone Number: _____ Can leave message? ☐ Yes ☐ No

Alternate Number: _____ Can leave message? ☐ Yes ☐ No

Email: _____ Preferred Language: _____

Date of Birth: month / day / year Health Card #: _____

Gender: ☐ Female ☐ Male ☐ Other Indigenous? ☐ Yes ☐ No

Medical Contact

Does the applicant **have a primary care provider** (physician or nurse practitioner)? ☐ Yes ☐ No

Name: _____ Agency/Clinic: _____

Phone Number: _____ Fax Number: _____

Existing Supports

If the applicant is currently working with any **other service providers**, please list below:

Agency 1: _____ Agency 2: _____

Contact Name: _____ Contact Name: _____

Contact Number: _____ Contact Number: _____

Does the applicant have access to an **Employee Assistance Program**? ☐ Yes ☐ No

Has the applicant been referred for **other mental health programs**? ☐ Yes ☐ No

Reason for the Referral

*Please briefly describe the **reason(s) for the referral**, including any **clinical questions**, **diagnoses**, description of symptoms, requested services, support needs, etc.*

Primary Symptom: _____ Secondary Symptom: _____

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Mental Health Risk Factors

To what degree is the applicant's daily **function impaired** by these symptoms? ☐ Mild ☐ Moderate ☐ Severe

Does the applicant have a chronic **history of mental health** problems? ☐ Yes ☐ No ☐ Not Sure

Is there a **formal diagnosis** of mental illness (if yes, please answer below)? ☐ Yes ☐ No ☐ Not Sure

Primary diagnosis: Secondary diagnosis:

Has the applicant **recently experienced psychosis**? ☐ Yes ☐ No ☐ Not Sure

First experience with psychosis? ☐ Yes ☐ No ☐ Not Sure

Is **excessive recreational drug, alcohol use, or gambling** a concern? ☐ Yes ☐ No ☐ Not Sure

Is this referral for **addictions treatment**? ☐ Yes ☐ No

Is there **current involvement** with an addictions treatment program? ☐ Yes ☐ No

Is there involvement with a **methadone program**? ☐ Yes ☐ No

Has the applicant had **suicidal thoughts** in the past month? ☐ Yes ☐ No ☐ Not Sure

Has a **plan** to suicide? ☐ Yes ☐ No ☐ Not Sure

Has **attempted** to suicide in the past month? ☐ Yes ☐ No ☐ Not Sure

Does the applicant have a history of **aggressive or destructive behaviour**? ☐ Yes ☐ No ☐ Not Sure

Has the applicant been to the hospital in the past year **due to mental health**? ☐ Yes ☐ No ☐ Not Sure

Is the applicant currently in/or discharged in the past month from the **hospital inpatient mental health program** (Adult Mental Health)? ☐ Yes ☐ No ☐ Not Sure

If female, is the applicant pregnant or has recently (24 mo.) given birth? ☐ Yes ☐ No

Is **peri-partum depression** a concern? ☐ Yes ☐ No ☐ Not Sure

Is the applicant **currently homeless or at risk** of becoming homeless? ☐ Yes ☐ No

Are **family/relationship issues** affecting the applicant's mental health? ☐ Yes ☐ No

Are **socioeconomic issues** affecting the applicant's mental health? ☐ Yes ☐ No

Is this applicant **transitioning from a youth mental health** program (check any that apply)?

☐ Child and Adolescent Psychiatry ☐ Children's Centre Thunder Bay ☐ Dilico

Other Illness/Disability

Does the applicant have any other illness/disability (check any that apply)?

☐ **Concurrent Disorders** (substance dependence with mental illness.)

☐ **Dual Diagnosis** (developmental impairment with mental illness.)

Currently receive service(s) through DSO (Developmental Services Ontario)? ☐ Yes ☐ No

If no, has an application been submitted? ☐ Yes ☐ No

☐ **Neurological** (head/brain injury, epilepsy, cognitive disorders etc.)

☐ **Active medical condition:**

☐ Auto-immune Condition ☐ Cancer ☐ Cardiac Disease ☐ COPD

☐ Diabetes ☐ HIV ☐ HEP ☐ HTN ☐ Stroke

☐ **Other chronic illness, physical disability, or sensory loss/deficit:** _____

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Diagnostic Assessments

*Does the applicant require a **diagnostic assessment** (check any that apply)?*

☐ **Diagnostic Clarification**:

What are your current diagnostic impressions?

☐ **Cognitive Assessment**:

What is your specific referral question?

☐ **Neuropsychological Assessment** (psychology):

What is your specific referral question?

Medication Review

Does the applicant require a **medication review**? ☐ Yes ☐ No

*If the applicant is **currently taking ANY medications**, please indicate below, or attach a medication list.*

Medication	Dosage\Frequency

Additional Information

Is this a psychiatry referral for an inpatient currently at St. Joseph's Hospital? ☐ Yes ☐ No

If the applicant has **had a psychiatric assessment/medication review done in past year**, please include the consult letter and summarize the reasons for re-assessment below:

Is this assessment **required for third party reasons** (i.e. Insurance, WSIB, Custody, Licensing)? ☐ Yes ☐ No

If yes, please summarize the reasons for assessment:

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Case Management and Housing Demographics

What is the applicant's primary **source of income**? _____

What is the applicant's **secondary** source of income? _____

What is the applicant's **estimated monthly income**? _____

What is the applicant's **employment status**? _____

What is the applicant's **level of education**? _____

Does the applicant have **any dependents**? ☐ Yes ☐ No ☐ Not Sure

What is the applicant's **marital status**? _____

Housing Preferences

Does the applicant require a **stair free or wheelchair accessible** unit? ☐ Yes ☐ No

Would the applicant **live in a shared accommodation** (house or apartment)? ☐ Yes ☐ No

Does the applicant require any of the following (check all that apply)?

☐ Requires non-clinical case management ☐ Requires clinical case management

☐ Require non-clinical 24/7 support ☐ Requires clinical 24/7 support

Please describe if the applicant has any medical or other needs:

Support Needs

Please indicate what areas of support the applicant would need from the list below:

Housing:
- ☐ Assistance Maintaining Home
- ☐ Hoarding/Diogenes

Social Support:
- ☐ Community Involvement
- ☐ Marital/Partner Issues
- ☐ Family Relationship Issues
- ☐ Overcoming Isolation
- ☐ Social and Peer Support

Health and Wellness:
- ☐ Managing Mental Illness
- ☐ Managing Physical Illness
- ☐ Managing Medication
- ☐ Managing Addiction
- ☐ Coping with Illness in Family

Maintaining Safety:
- ☐ Avoid Unsafe Situations
- ☐ Self-Harm

Food and Nutrition:
- ☐ Nutrition and Diet Info
- ☐ Shopping
- ☐ Assistance with Meal Prep
- ☐ Need Meals Delivered

Daily Activities:
- ☐ Using transportation
- ☐ Adding structure to the day
- ☐ Developing Daily Living Skills

Finances:
- ☐ Financial Management
- ☐ Access to Financial Supports

Legal:
- ☐ Legal issues
- ☐ Self-advocacy/Legal Rights

Employment and Education:
- ☐ Education
- ☐ Improving Employability

Past Supports

If the applicant worked with any **other service providers in the past**, please list below:

Agency 1: _____ Agency 2: _____

Contact Name: _____ Contact Name: _____

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Chronic Pain

Date of on-set of the pain: month / day / year

Is the applicant **medically stable**? ☐ Yes ☐ No

Are there any barriers to learning? ☐ Yes ☐ No

Are there any barriers to working in groups? ☐ Yes ☐ No

Able to **participate in aerobic/muscle strengthening** exercise? ☐ Yes ☐ No

Does the applicant have a **history of chronic mental health** problems? ☐ Yes ☐ No

To what degree is the applicant's daily function impaired by pain?

- ☐ Mild (intermittent difficulties at home/work)
- ☐ Moderate (on-going difficulties at home/work, social activities, and psychosocial symptoms)
- ☐ Severe (unable to work, no social activities, severe/persistent psychological symptoms)

Please describe any restrictions for exercise and any medical conditions that would pose a barrier to participation in the program:

Interventions Requested:

- ☐ Diagnostic clarification
- ☐ Counseling/psychotherapy
- ☐ Psychosocial interventions
- ☐ Pain self-management education
- ☐ Anesthesia intervention
- ☐ Medication consultation
- ☐ Psycho-educational groups
- ☐ Sleep strategies
- ☐ Strategies to improve physical function
- ☐ Clinical questions: _____
- ☐ Other: _____

Requirements for Triage (relevant to reason for referral), please include:

- Medical history (co-morbidities).
- Copies of specialty consultations/pending appointments.
- Past/pending investigations.
- Copies of diagnostics (CT scans, MRIs, X-rays).
- Consultations/imaging outside of Meditech EMR.
- Last year of lab work.
- Description of current management plan (please include all current prescribed medication).

Additional comments: