Children's Hospital
London Health Sciences Centre

Child and Adolescent Mental Health Care Program: Inpatient Tertiary Care

Children's Hospital
London Health Science Centre
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ATTACHMENTS:

- ☐ **CURRENT LEGAL FORMS**
- ☐ CRISIS/SAFETY PLAN
- ☐ RAI-MH *(IF ATTACHING, COMPLETE SECTIONS A, B, C, E AND G ONLY)*
- ☐ COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)
- ☐ NURSING NOTES
- ☐ CURRENT MEDICATION ADMINISTRATION RECORD
- ☐ OT/PSYCH/SW ASSESSMENTS
- ☐ PHYSICIAN'S NOTE
- ☐ CARE PLANS

SECTION A

NAME OF CLIENT _____
(LAST/FAMILY NAME) (FIRST NAME) (MIDDLE/INITIAL)

DOB: | | | | | | | | | HEALTH CARD #: | | | | | | | | | | | VERSION

Y Y Y Y M M D D

AGE: | | SEX: ☐ M ☐ F ☐ T CURRENTLY IN HOSPITAL? ☐ Yes ☐ No If Yes, admission date: | | | | | | | | |

STATUS: ☐ Voluntary ☐ Involuntary

ADDRESS _____ Telephone: | | | | | | | | | | | |
(STREET) (CITY/TOWN/POSTAL CODE)

Next of Kin:_____ Relationship _____ Telephone: | | | | | | | | | | | |

Family Physician:_____ Telephone: | | | | | | | | | | | |

Community Psychiatrist:_____ Telephone: | | | | | | | | | | | |

Other community supports (natural/formal):_____ Telephone: | | | | | | | | | | | |

_____ Telephone: | | | | | | | | | | | |

_____ Telephone: | | | | | | | | | | | |

SECTION B – CURRENT STATUS

Capable to consent to treatment ..... ☐ Yes ☐ No If no, SDM:_____ Tel: | | | | | | | | | | | |

Capable to manage property..... ☐ Yes ☐ No If no, guardian:_____ Tel: | | | | | | | | | | | |

Capable to disclose info. related to clinical record.. ☐ Yes ☐ No If no, SDM:_____ Tel: | | | | | | | | | | | |

Legal Guardian forreferred adolescent (if applicable):_____ Tel: | | | | | | | | | | | |

Is client or SDM (if applicable) aware of and in agreement with referral for admission? ☐ Yes ☐ No

Is client's family aware and in agreement? ☐ Yes ☐ No ☐ N/A

SECTION C – REFERRAL GOALS

	Client	Client's Family	Referral Source
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐

_____

_____

SECTION D

PSYCHIATRIC DIAGNOSES: _____

MEDICAL DIAGNOSES: _____

PSYCHOSOCIAL STRESSORS: _____

RESIDENTIAL STATUS: ☐ Private home/apt ☐ Assisted living/group home ☐

☐ Repatriate to Community Hospital ☐ No Fixed Address ☐ Other _____

CLIENT CAN RETURN POST-DISCHARGE? ☐ Yes ☐ No SOURCE OF INCOME: _____

CURRENT LEGAL STATUS: ☐ No legal problems ☐ Currently on probation/ parole ☐ Recently incarcerated

☐ Currently in a court diversion/support program ☐ Restraining order(s) present ☐ Outstanding charge(s) _____

☐ Community Treatment Order ☐ Student (School Name)_____

SECTION E

Client has a past history of suicide ideation/attempts? ☐ Yes ☐ No Client has a past history of violence? ☐ Yes ☐ No

If yes, details required _____

Is client currently suicidal? ☐ Yes ☐ No Is client currently violent? ☐ Yes ☐ No

If yes, details required _____

☐ Non-ambulatory or assisted ambulation ☐ Blindness/vision impairment ☐ Learning disability Seizures

☐ Language/cultural ☐ Deafness/hearing loss ☐ Cognitive impairment ☐ Other (specify) _____

☐ Speech impairment ☐ Incontinence ☐ Head injury _____

SECTION F

Number of psychiatric admissions in the last two years:_____(If # of admissions > 0, Number of days in psychiatric hospital/unit in the last two years:_____)

Number of months since discharge from last mental health admission:_____or ☐ Not applicable

Number of days since last contact with a community mental health agency or mental health professional in the past year: or ☐ No contact in last year

SECTION G – MEDICATIONS

☐ Current MAR attached **OR** ☐ List of all active prescriptions attached

Referral form completed by:_____ Title: _____

Organization:_____

Telephone: Ext: Fax:

Signature:_____ Date Completed: Y Y Y Y M M D D

Print Form