St Joseph's Health Care London
Parkwood Institute Mental Health Care Program
Steele Street Rehabilitation Residence Referral form
Fax: 519-631-1741

Please note Steele Street is a substance free environment. Must be 6 months abstinent prior to referral

DATE ______________________________

REFERRAL SOURCE: ______________________________

CLIENT NAME: ______________________________

CURRENT ADDRESS: ______________________________

HOME PHONE NUMBER ____________________

LEGAL STATUS

Mental Health Act

☐ Voluntary ☐ Involuntary Form # ________ Expiry Date: ____________

☐ Contesting involuntary form

☐ Community Treatment Order Expiry Date: ____________________

Criminal Code (forensic referrals)

☐ Criminal record ☐ Ontario Review Board (Unfit/NCR) Probation: ☐ Yes ☐ No

Current Charges: ☐ Yes ☐ No If yes, please describe

Psychiatric Diagnosis (es) (if known or suspected)

Medical Diagnosis (es) (if known or suspected)

Level of Urgency and Rationale

Allergies (describe):

Capacity to Consent

Capable to Consent to Treatment: ☐Yes ☐ No ☐ Unknown

If no, please identify substitute decision maker/power of attorney/PGT

Capable to Manage Property: ☐ Yes ☐ No ☐ Unknown

If no, please identify substitute decision maker/power of attorney/PGT

Financially Competent: ☐ Yes ☐ No

Public Trustee: ☐ Yes Contact: ______________________

☐ No

Income:

☐ Employment Insurance ☐ ODSP Contact: ______________________

☐ Pension ☐ No Income

☐ Social assistance ☐ Other: ______________________

PREVIOUS PSYCHIATRIC ADMISSIONS: ☐ Yes ☐ No

Last D/C Date: ______________________

Location: ______________________

Number of hospital days in the last 2 years: __________

Is client connected with community mental health agency/services? ☐Yes ☐No

If yes, please specify agencies:

Housing:

☐ Lives alone

☐ Lives with family

☐ Lives with non-relatives

☐ Supportive Housing (Please specify)

____

Persistent Functional Deficits:

☐ Inadequate social support network

☐ Needs assistance with basic living skills

☐ Inappropriate social behavior

☐ Other: ______________________

Presenting Problems: (please check all that apply)

☐ Coexisting substance use disorder
☐ Community tenure at risk
☐ Requires more than 8hrs/month Of direct professional service
☐ Currently homeless
☐ Currently in hospital
☐ Persistent and severe symptoms
☐ High use of emergency or crisis services
☐ Unsuccessful previous attempts to engage in treatment
☐ High risk or recent history of criminal justice involvement
☐ Inability to sustain employment and/or homemaking role
☐ Other

Reason for Referral/Factors Contributing to Current Referral

Rehab Needs: (Please check all that apply)

☐ Medication education
☐ ADLS
☐ Finances (money management)
☐ Nutrition
☐Productivity (education, employment)
☐ Insight
☐ Symptom management
☐ Memory
☐ Coping (stress/anger management)
☐ Social skills
☐ Cognitive Skills
☐ Meal planning/kitchen safety
☐ Community engagement
☐ Transportation
☐ Daily structure
☐ Other

Risks: (Please check all that apply)

☐ Medication non-adherence
☐ Suicide
☐ Self Harm
☐ Violence towards others
☐ Drug misuse
☐ Living alone
☐ Wandering/Elopement
☐ Sexual aggression
☐ Weapons
☐ Arson/Fire setting
☐ Alcohol misuse
☐ Substance abuse
☐ Eating disorders
☐ Choking/Aspiration/Dysphagia
☐ Gambling
☐ In home (describe) ____
☐ Falls – if yes, describe functional mobility/assistive devices: ___________________________

Physical Health

Medical concerns:

OT Assessments
Client goals and why is Steele necessary for this?

Authorization for Release of Information
Signed and attached: ☐ Yes ☐ No

Documents needed to facilitate Steele Referral

☐ Current medication list ☐ Nursing/medical summaries
☐ Most recent treatment plan ☐ Occupational Therapy assessment

This section to be filled out by the client
What are the goals you would like to work on in the up to 2 year time frame?

Referral Status

Client aware of referral: ☐ Yes ☐ No

Client agreeable to referral: ☐ Yes ☐ No

Client Signature: ____

Date: ____