Intensive Case Management Access Coordination (IntĀc)
SELF REFERRAL

please COMPLETE FORM and fax to 905-546-0055; or mail to IntĀc, #405 - 20 Hughson St. S., Hamilton, ON,

NOTE: Street Outreach referrals can be made by:
(a) faxing *page one only* of this form, or (b) calling IntĀc: ***905-528-0683***

***** = must complete***

Requested Service ☐ Street Outreach (homeless) ☐ Intensive Case Management

Date of Referral:**

Your Information

Name:**	DOB:*(YYYY MM DD)*	Age:	Gender:**	Marital Status:	☐ Aboriginal ☐ Non-Aboriginal

Health Card #: VC:

Do you require accommodation?** ☐ Yes ☐ No
If yes, provide detail:

Address / Emergency Shelter / Last Location Seen:**

Physical Description:** *for Street Outreach Only*

Phone #:** *if available*

Do you speak/understand English?** ☐ Yes ☐ No
Preferred Language:

Emergency Contact Information:** *if available*

Employment (current status):

Highest level of education:

Do staff need to be aware of any past or current safety issues (self or others)?** *If yes, explain:* ☐ Yes ☐ No

Family Doctor / Nurse Practitioner	**Psychiatrist**
Name:	Name:
Phone:	Phone:
Fax:	Fax:
Office Address:	Office Address:
Is family doctor/NP aware of referral? ☐ Yes ☐ No	Is psychiatrist aware of referral? ☐ Yes ☐ No

Permission to contact your healtcare providers? ☐ Yes ☐ No ☐ N/A

Current Supports / Contacts *(professional, family, friends, peers, etc.; Please indicate if Substitute Decision Maker)*

Name:	Relationship:	Phone:

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Specialists or Other Agencies Involved ***(include past supports)***

Current or past services involved:	Details: (e.g. agency, contact, date of service)
☐ counselling services	
☐ vocational services	
☐ addiction services	
☐ mental health services / treatment	
☐ Children's Aid Society	
☐ housing program	
☐ other ***(specify)***	

Are you currently referred to other agencies? (If "Yes" please specify)

Mental Health:

Diagnoses:

How could Intensive Case Management services support you? (i.e. how does your mental health affect your ability to live well?)

Current and Past Psychiatric History ***(please check and make comments where relevant)***

☐ Suicide History

☐ Aggressive Behaviour

☐ Substance Abuse / Addictions

☐ Hospitalization History

☐ Community Treatment Order (if "Yes" please provide documentation)

☐ Vulnerability to Risk / Exploitation

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Current and Past Medical History

Medical Diagnoses:

Acquired Brain Injury / Traumatic Brain Injury	☐ Yes	☐ No	(If "Yes" please indicate impact on functioning)
Developmental Disability	☐ Yes	☐ No	(If "Yes" please indicate impact on functioning)

Current Medications ***(if more space required, please attach list)*** **Document Allergies**

Current and Past Legal History

Are you currently on probation/parole?	☐ Yes ☐ No	(If "Yes" please indicate name of probation/parole officer)
Were you previously on probation/parole?	☐ Yes ☐ No	
Ontario Review Board	☐ Yes ☐ No	

Rehabilitation Goals

Comments

Please provide any other relevant information as needed: