Intensive Case Management Access Coordination (IntĀc)
Service Request Form

please COMPLETE FORM and fax to 905-546-0055; or mail to IntĀc, #405 - 20 Hughson St. S., Hamilton, ON, L8N 2A1

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 (client is homeless) ☐ Intensive Case Management

Date of Referral:**

Client Information

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

Health Card #: VC:

Does client require accommodation?** ☐ Yes ☐ No
If "Yes", explain:

Address / Emergency Shelter / Last Location Seen:**

Physical Description of Client:** *for Street Outreach Only*

Phone #:** *if available*

Can client speak/understand English?** ☐ Yes ☐ No
Preferred Language:

Emergency Contact Information:** *if available*

Employment (current status):

Highest level of education:

Referral Source Self Referral?** ☐ Yes ☐ No *If no* Is client aware of referral?** ☐ Yes ☐ No

Name: **

Position / Title:

Agency Name:** *if applicable*

Phone:** *if applicable* Ext.: Fax:

Referral Source (role, frequency of interaction, length of time involved, and client's response to treatment):** *if applicable*

Referring Physician name (please print) Referring Physician Signature OHIP Billing #

Primary Care Provider	**Psychiatrist**
Name:	Name:
Phone:	Phone:
Fax:	Fax:
Office Address:	Office Address:
Is family physician aware of referral? ☐ Yes ☐ No	Is psychiatrist aware of referral? ☐ Yes ☐ No

Has the client provided verbal permission to contact his/her healthcare 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 referring the client to other agencies? (If "Yes" please specify)

Mental Health:

Diagnoses:

Rationale for referral to Intensive Case Management services (ie. how does client's mental health affect their 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 (If "Yes" please indicate i	☐ 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

Is the client currently on probation/parole?	☐ Yes ☐ No	(If "Yes" please indicate name of probation/parole officer)
Was client previously on probation/parole?	☐ Yes ☐ No	
Ontario Review Board	☐ Yes ☐ No	(If "Yes", please provide documentation)

Do staff need to be aware of any past or current safety or behavioural issues when approaching the client?** ☐ Yes ☐ No *If yes, explain:*

Rehabilitation Goals

Goals identified by client:

Comments

Please provide any other relevant information as needed: