Waypoint
CENTRE for MENTAL HEALTH CARE
CENTRE de SOINS de SANTÉ MENTALE

Advancing Understanding. Improving Lives.
Avancer la compréhension. Améliorer la vie.

Clear Form | Print Form

REFERRAL FORM

Complete and fax to 705.549.1812
Phone 705.549.3181 x 2308
Toll Free 1.877.341.4729 x 2308
Website: www.waypointcentre.ca

Please note: we are not a crisis or emergency service

If you feel that your patient is too ill to tolerate the wait for an assessment/admission, please consider accessing a psychiatric crisis service or emergency room at the nearest hospital serving your patient's community

1. Referral Date: _____ (yyyy/mm/dd) **Request:** ☐ Inpatient ☐ Outpatient ☐ Consultation ☐ Service

Client Aware of Referral: ☐ Yes ☐ No **Client Agrees to Referral:** ☐ Yes ☐ No

2. Last Name: _____ **First Name:** _____ **Middle:** _____

Also Known As (list all that apply): _____

Birthdate: _____ (yyyy/mm/dd) If Unknown, Estimated Age: _____ Gender: ☐ Male ☐ Female ☐ Other

Address: _____ (number) _____ (unit) _____ (street name) _____ (city)

_____ (province) _____ (postal code) _____ (country)

Phone: _____ (primary) _____ (ext) _____ (alternate) _____ (ext)

Permission to Leave Voicemail: ☐ Yes ☐ No

Language(s) Spoken: ☐ English ☐ French ☐ Other Preferred Language: _____

Marital Status: ☐ Single/Never married ☐ Married ☐ Common-law ☐ Separated ☐ Divorced ☐ Widowed ☐ Unknown

Health Card Number: _____ Version: _____ Expiry Date: _____ (yyyy/mm/dd) Issuing Province/Territory: _____

3. Next of Kin

Last Name: _____ First Name: _____

Address: _____

Phone: _____ (primary) _____ (ext) _____ (alternate) _____ (ext)

Relationship to Client: _____

4. Emergency Contact ☐ Same as next of kin

Last Name: _____ First Name: _____

Address: _____

Phone: _____ (primary) _____ (ext) _____ (alternate) _____ (ext)

Relationship to Client: _____

5. Reason for Referral/Factors Contributing to Current Referral (please include environmental stressors)

☐ Inability to care for self due to mental illness ☐ Poor functioning in community ☐ Symptoms of mood ☐ Other
☐ Medication review and stabilization ☐ Substance misuse ☐ Symptoms of anxiety
☐ Diagnostic clarification ☐ Threat or danger to self ☐ Symptoms of psychosis
☐ Involvement with criminal justice system ☐ Threat or danger to others ☐ Signs of cognitive impairment

Goal of Consultation/Assessment:

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Last Name: _____ First Name: _____ Middle: _____

Psychiatric Diagnosis(es) (if known or suspected):

Medical Diagnosis(es) (if known or suspected):

Level of Urgency and Rationale: _____

6. Allergies (describe): _____

7. Risks

- ☐ Medication non-adherence
- ☐ Sexual aggression
- ☐ Drug misuse
- ☐ Living alone
- ☐ Gambling
- ☐ Suicide
- ☐ Weapons
- ☐ Street drugs
- ☐ Eating disorders
- ☐ Self harm
- ☐ Arson/Fire setting
- ☐ Prescription
- ☐ Wandering/Elopement
- ☐ Violence towards others
- ☐ Alcohol misuse
- ☐ Tobacco/Nicotine use
- ☐ Choking/Aspiration/Dysphagia
- ☐ Falls If yes, describe functional mobility/assistive devices: _____
- ☐ In home (describe): _____ ☐ Other (describe): _____

8. Legal Status

Mental Health Act

☐ Voluntary ☐ Involuntary Form #: _____ Expiry Date: _____ (yyyy/mm/dd) ☐ Contesting involuntary form

☐ Community Treatment Order Expiry Date: _____ (yyyy/mm/dd)

Criminal Code (forensic referrals)

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

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

9. Capacity to Consent

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

If no, please identify Substitute Decision Maker/ Power of Attorney/Public Guardian & Trustee: _____ (name) _____ (phone)

Capable to Manage Property: ☐ Yes ☐ No ☐ Unknown

If no, please identify Substitute Decision Maker/ Power of Attorney/Public Guardian & Trustee: _____ (name) _____ (phone)

10. Functional Abilities

Personal Hygiene:	☐ Independent	☐ Needs prompts	☐ Needs assistance	
Special Senses:	☐ Visual impairment	☐ Hearing impairment		
Ambulation:	☐ Walks without assistance	☐ Walks with assistance	☐ Unsteady	☐ Wheelchair/Walker
Eating:	☐ Independent	☐ Needs prompts	☐ Needs assistance	
Sleep:	☐ Normal	☐ Insomnia	☐ Daytime sleeper	
Communication:	☐ Receptive challenge	☐ Expressive challenge		
	☐ Requires interpreter	specify: _____		

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Last Name: _____ First Name: _____ Middle: _____

11. Income Sources (please specify): _____

12. Housing

- ☐ Private home/Apartment
- ☐ Setting for persons with intellectual disabilities
- ☐ Homeless/Shelter
- ☐ Long-term care facility/Retirement home
- ☐ Mental health residence (e.g. psychiatric group home)
- ☐ Correctional facility
- ☐ Other (specify): _____

13. Collateral Information (please attach)

- ☐ Admission/Discharge summaries
- ☐ Diagnostic imaging
- ☐ RAI/OCAN
- ☐ Lab values
- ☐ Psychological assessments
- ☐ Functional assessments
- ☐ Consultations
- ☐ Medication list/Medication Administration Record (MAR)
- ☐ Psychosocial assessment

14. Service(s) Requested (please see Appendix for descriptions)

Acute Inpatient
- ☐ Acute Assessment Program

Tertiary Inpatient
- ☐ Bayview Program for Dual Diagnosis
- ☐ Georgianwood Program for Concurrent Disorders
- ☐ Horizons Program for Geriatric Psychiatry
- ☐ Sans Souci Program for Transition & Recovery

Forensic Inpatient
- ☐ Provincial Forensic Programs
- ☐ Brébeuf Program for Regional Forensics

Behavioural Support System (BSS)
- ☐ Mobile Support Team (MST)

Community Based Services
- ☐ Behavioural Intervention and Response Team
- ☐ Electroconvulsive Therapy (ECT)
- ☐ Geriatric Psychiatry Outreach Team
- ☐ Homes for Special Care (required forms)
- ☐ Waypoint Outpatient Services
- ☐ Rehabilitation Services
- ☐ Transitional Age Youth

Unknown ☐

15. Referring Physician/Psychiatrist/Nurse Practitioner ☐ Unknown

Last Name: _____ First Name: _____ Phone: _____

Primary Health Care Provider (if different from above) ☐ Unknown

Last Name: _____ First Name: _____ Phone: _____

Community Agency/Resources Involved (past or present): _____

16. Referral Completed By: _____ (please print) Signature: _____

Agency Name: _____ Phone: _____ Fax: _____

Admission Date to Referral Source: _____ (yyyy/mm/dd) Estimated Discharge Date from Referral Source: _____ (yyyy/mm/dd)

Do you have access to telemedicine or videoconferencing? ☐ Yes ☐ No

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website: www.waypointcentre.ca

Office Use Only:

Date Referral Received: _____ (yyyy/mm/dd)
Date Referral Completed: _____ (yyyy/mm/dd)
Date Referral Sent to Program: _____ (yyyy/mm/dd)
Date Decision Made or Call: _____ (yyyy/mm/dd)
Date Access for Service: _____ (yyyy/mm/dd)
MRN: _____

Appendix

Program Descriptions

Acute Program	Description
Acute Assessment Program	**Age:** 16 years of age and older **Service Area:** North Simcoe Muskoka LHIN **Referrals Accepted from:** Emergency room, community mental health programs **Type of Service:** Acute mental health provides: short term crisis intervention, risk assessment, symptom reduction, rapid stabilization and active treatment for people who require more support than can be provided in the community.
Tertiary Inpatient Programs	**Description**
Bayview Program for Dual Diagnosis	**Age:** 16 years of age and older **Service Area:** Waypoint catchments, Simcoe, Dufferin Counties, South Muskoka to Parry Sound and Huntsville **Referrals Accepted from:** Psychiatrist and/or physician **Type of Service:** The Bayview Program for Dual Diagnosis offers psychiatric assessment and treatment to individuals with a developmental disability and mental health needs. Bayview is comprised of a 16 bed in-patient program.
Georgianwood Program for Concurrent Disorders	**Age:** 16 years of age and older **Service Area:** Waypoint service region **Referrals Accepted from:** Psychiatrist and/or physician **Type of Service:** Assessment and integrated mental health and addictions treatment in a 3-month residential program, which includes graduated passes home, transitional discharge, family support, and aftercare. The program was developed on best-practice recommendations and the clinical focus is on learning effective skills for recovery.
Horizons Program for Geriatric Psychiatry	**Age:** 65 years of age and older with an existing mental illness and/or severe behaviours related to a dementia or under 65 with a neurodegenerative disease process and mental illness **Service Area:** Waypoint service region **Referrals Accepted from:** Psychiatrist and/or physician **Type of Service:** Provides specialized geriatric assessment, diagnosis, treatment and stabilization of mental illness and/or severe behaviours related to a dementia with the aim to reintegrate to the community.
Sans Souci Program for Transition and Recovery	**Age:** 16 years of age and older **Service Area:** Waypoint service region **Referrals Accepted from:** Acute mental health programs and community mental health agencies **Type of Service:** Specializes in assessment, treatment and recovery of individuals with a severe and persistent mental illness. Partners with community mental health agencies for transitional discharge support.
Forensic Inpatient Programs	**Description**
Provincial Forensic Programs	*Under Development*
Brébeuf Program for Regional Forensics	*Under Development*
Community Based Programs	**Description**
Homes for Special Care	**Age:** Adults 18 years of age and older **Service Area:** Simcoe and Muskoka **Referrals Accepted from:** Clinical services including - Schedule 1 mental health facilities; community mental health agencies; hospitals. **Exclusionary Criteria:** Developmental diagnosis; dual diagnosis; active criminal charges; active alcohol/substance abuse; complex medical issues requiring nursing care. **Type of Service:** Provides a 24-hour residential supportive housing program to those who have a mental health diagnosis, been consumers of mental health services, and would benefit from a group living environment in a community setting. Privately owned and operated homes are licenced under the MOHLTC. Clinical services and program administration are provided by Waypoint.

Appendix

Program Descriptions

Community Based Programs (cont.)	Description
Waypoint Outpatient Services	**Age:** 16 years of age and older (youth who are identified as having complex needs and will require longer term support/treatment) **Service Area:** North Simcoe County **Referrals Accepted from:** Physicians, nurse practitioners, mental health agencies **Type of Service:** Assessment, treatment and support for people who are experiencing symptoms of serious mental illness. May include first occurrence of the illness, or an individual requiring longer term intervention.
Transitional Age Youth Psychiatric Consultation Service	**Age:** 16 - 24 years of age **Service Area:** Midland/Penetanguishene and surrounding communities, expanding gradually to Muskoka **Referrals Accepted from:** Self, family, or service provider but must have the support of a primary care practitioner (physician, pediatrician or nurse practitioner) **Type of Service:** TAY offers a one-time psychiatric consultation via the Ontario Telehealth Network (OTN) assisting with diagnosis, treatment advice and recommended follow up with the goal of supporting effective early intervention.
Rehabilitation Services	**Age:** 16 years of age and older **Service Area:** Midland/Penetanguishene and surrounding communities **Referrals Accepted from:** Self, family (with consent of individual), and health provider **Type of Service:** Rehabilitation Services supports patients/clients in achieving their goals in employment, education, and recreation, and includes the integration of peer support workers who have lived experience navigating their recovery. Our services are offered at the Provincial, Regional, and Hero Centre sites, and the surrounding community.
Geriatric Psychiatry Outreach Program	**Age:** 65 years of age and older with an existing mental illness and/or severe behaviours related to a dementia or under 65 with a neurodegenerative disease process and mental illness. **Service Area:** Waypoint service region **Referrals Accepted from:** Psychiatrist, physician and nurse practitioner **Type of Service:** Provides specialized geriatric psychiatry consultation that includes diagnosis, treatment and behavioural recommendations that will assist the primary care provider with their treatment plan for their patient.
Behavioural Intervention Response Team (BIRT)	**Age:** 65 years of age and older with a documented diagnosis of dementia **Service Area:** North Simcoe Muskoka LHIN **Referrals Accepted from:** Physician referral from Long Term Care Homes (LTCH). Referrals are accepted 24/7. **Type of Service:** A specialized psychogeriatric response team designed to provide an intensive behavioural approach to clients exhibiting severe behaviours. BIRT is an alternative to hospitalization for residents in LTCH with severe behaviours related to dementia.
Electroconvulsive Therapy (ECT)	**Age:** 16 years of age and older **Service Area:** North Simcoe Muskoka LHIN **Referrals Accepted from:** Psychiatrist, family physicians, self and family **Type of Service:** Provides assessment, consultation, education and case management for individuals receiving ECT.
Mobile Support Team (part of the Behavioural Support System) *(collaboration between Waypoint, Alzheimer Society of Greater Simcoe County, Collingwood General and Marine Hospital, Canadian Red Cross, Wendat Community Programs and Georgian Manor LTC (County of Simcoe))*	**Age:** Older adults living in the community or in Long-term Care **Service Area:** North Simcoe Muskoka LHIN **Referrals Accepted from:** Family, self, agencies, and physician referral is **not** required **Type of Service:** The purpose of the Mobile Support Team (MST) is to keep people in their home environment (LTC and community) and to assist them to remain connected to their current supports in a culture of safety and well-being when experiencing responsive behaviours as a result of a dementia, neurological disorders, mental health and/or addictions. The Mobile Support Team will enhance existing resources in a model of collaborative care with input and direction from the client and family members.