



Case Management Referral/Client Form

We only collect data for accurate assessment and in compliance with the funder's requirement. Please provide data for the items in this form as much as you can. Fill out at least all fields with * and ** Please type or make your handwriting legible to avoid delay in processing the referral. Your time and effort are much appreciated.

Please send the completed form to: **Hong Fook Mental Health Association**
260 Spadina Avenue, Suite 408, Toronto, Ontario M5T 2E4, or by fax to (416) 595-6332
 For **urgent referrals**, please call our Intake Worker (Tel: 416-493-4242 Ext. 0) before you fax.

Client Information

1. _____ 2. _____ 3. _____
 *Last Name *First Name Middle Name

4. □□□-□□□-□□□□ 5. □□□-□□□-□□□□ Ext. _____ 6. □□□-□□□-□□□□
 Home Phone Number Work Phone Number Cell Phone Number

7. □□□-□□□-□□□□ 8. _____
 Fax Number Email

9. Address:

Street	Apt.	City	Province
Postal Code			

10. *Client/Recipient location:
 Toronto Durham Peel York Out of Province
 Other, specify: _____ Unknown or Service Recipient Declined

11. *Client/Recipient LHIN:
 Central Central East Central West Toronto Central Mississauga Halton
 Other, specify: _____ Unknown or Service Recipient Declined

12. *Gender:
 Female Male Other, specify: _____ Unknown or Service Recipient Declined

13. *Date of Birth: □□□□-□□-□□(yyyy/mm/dd) If Unavailable, Estimated Age: _____

14. *Service Languages (language used in contacting Hong Fook worker):
 Cambodian (Khmer) Cantonese English
 Korean Mandarin Vietnamese
 Other, specify: _____ Unknown or Service Recipient Declined

15. *Client's Preferred language (choose one from above): _____ Other, specify: _____

16. ****First Knowledge of Hong Fook:**

- Family/Friends
- Professional
- Other, specify: _____
- Mass Media
- Publication (including websites)
- Unknown or Service Recipient Declined

Personal Information

1. ****Consent given to referral:**

- Verbal
- Written
- Nil
- Unknown

2. **Target Community:**

- Cambodian
- Cantonese
- Korean
- Mandarin (Mainland)
- Mandarin (Taiwan)
- Vietnamese
- Other, specify: _____

3. ***Highest Level of Education:**

- No formal schooling
- Elementary/Junior High School
- Secondary/High School
- College/University
- Some Elementary/Junior High School
- Some Secondary/High School
- Some College/University
- Unknown or Service Recipient Declined

4. **Year of Arrival to Canada:** _____

5. **Legal Status:**

- Citizen
- Undocumented Resident
- Landed Immigrant
- Other, specify: _____
- Refugee
- Unknown

6. **Social Insurance Number:** □□□-□□□-□□□ 7. **OHIP Number:** _____

8. **English Ability:** None A little Some Good Very good

9. **Birth Place:**

- Cambodia
- Canada
- China
- Hong Kong
- Korea
- Laos
- Taiwan
- Vietnam
- Other, specify: _____
- Unknown

10. **Culture:**

- American
- Chinese(Hong Kong)
- Vietnamese Chinese
- Cambodian
- Chinese (Taiwan)
- Other, specify: _____
- Canadian
- Korean
- Chinese (China)
- Vietnamese
- Unknown or Service Recipient Declined

11. **Religion:**

- Atheist
- Other, specify: _____
- Buddhist
- Christian
- Unknown or Service Recipient Declined
- Muslim

12. **Marital Status:**

- Single
- Widowed
- Other, specify: _____
- Married
- Domestic Partner
- Unknown or Service Recipient Declined
- Separated
- Separated Domestic Partner

13. **Structured Day-Time Activities:** No Unknown Yes, specify: _____

14. Emergency Contact List:

Name of Contact Person	Phone (Home/Work /Mobile)	Relationship
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Medical History

1. ***Primary Diagnostic Category** (choose one from list below): _____

2. ****Other Diagnostic Category** (can choose more than one):

- | | |
|---|---|
| <input type="checkbox"/> Adjustment Disorder | <input type="checkbox"/> Impulse Control Disorders not elsewhere classified |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Mental Disorders due to General Medical Condition |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Other Mood Disorder |
| <input type="checkbox"/> Delirium, Dementia, Amnestic and Cognitive Disorders | <input type="checkbox"/> Personality Disorders |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Sexual and Gender Identity Disorders |
| <input type="checkbox"/> Developmental Handicap | <input type="checkbox"/> Schizophrenia and other Psychotic Disorder |
| <input type="checkbox"/> Disorder of Childhood/Adolescence | <input type="checkbox"/> Sleep Disorders |
| <input type="checkbox"/> Dissociative Disorders | <input type="checkbox"/> Somatoform Disorders |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Substance Related Disorders |
| <input type="checkbox"/> Factitious Disorders | <input type="checkbox"/> Unknown or Service Recipient Declined |
| | <input type="checkbox"/> Not Applicable/None |

3. ***Other Illness Information:**

- Concurrent Disorder (Substance Abuse) Dual Diagnosis (Developmental Handicap)
 Other Chronic Illnesses and/or Physical Disabilities Not applicable/none

4. **Age of Onset of Mental Illness:** _____ years old

5. **Age of First Psychiatric Hospitalization:** _____ years old

6. **History of Out-patient Treatment:** Yes Never Unknown

Out-patient Treatment Provider:

Name	Title	Phone
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Visit: Regular Visit when needed No longer visit

7. ***Community Treatment Orders:** Issued CTO No CTO Unknown or Service Recipient Declined

8. **Description of Impact of Mental Illness/Problem(s) (e.g. symptoms, complaints):**

9. **Compliance with Medication:** Yes No Unknown

10. Aggression History Towards Others/Self: () Yes () No () Unknown

<u>Nature</u>	<u>To Whom</u>	<u>Date</u> (yyyy/mm/dd)	<u>Degree of Injury</u>	<u>Reason for Behaviors</u>	<u>Under Psychiatric Treatment?</u> (Yes/No)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

11. Any Communicable Disease? () No () Unknown () Yes, specify: _____

DSM IV

Date (yyyy-mm-dd): _____

Axis I: _____
Axis I – Focus 2: _____
Axis I – Focus 3: _____
Axis II: _____
Axis II – Focus 2: _____
Axis II – Focus 3: _____
Axis III: _____

Axis IV:

- () Economic Problems
- () Housing Problems
- () Problems related to interaction with the legal system/crime
- () Problems related to the social environment
- () Problems with access to health care services
- () Problems with primary support group
- () Other psychological and environmental problems
- () Educational Problems
- () Occupational Problems

GAF score: _____

Source of Referral

1. *Source of Referral (choose one only):
- () General Hospital
 - () Psychiatric Hospital
 - () Other Institutions
 - () Community Mental Health & Addiction (CMH&A) - Case Management
 - () CMH&A - ACT Team
 - () CMH&A - Counselling and Treatment
 - () CMH&A - Early Intervention
 - () CMH&A - Crisis Intervention
 - () CMH&A - Support within Housing
 - () CMH&A - Information & Referral

- CMH&A - Other Community Mental Health & Addiction Service
- Other Community Agency
- Family Physician
- Psychiatrist
- Mental Health Worker
- Criminal Justice System (CJS) - Police
- CJS - Court (includes Court Support and Diversion Program)
- CJS – Correctional Facilities (includes jails and detention centres)
- CJS - Probation/Parole Office
- CJS - Short Term Residential Safe Bed
- CJS - Source Breakdown Not Available
- Self, Family or Friend
- Other, specify: _____

2. Other Service Provider Information:

	Service Provider A	Service Provider B	Service Provider C
Start Date			
Provider Name			
Facility			
Position			
Address			
Email			
Phone			
Fax			

3. *Presenting Issues (can check more than one):

- Educational
- Financial
- Housing
- Legal
- Occupational/employment/vocational
- Other, specify: _____
- Physical/sexual abuse
- Problems with relationships
- Problems with substance abuse/addictions
- Specific symptom of serious mental illness
- Threat to others/attempted suicide
- Activities of daily living (refers to self care, personal hygiene, meal preparation, managing medications, banking, etc.)

4. Referrer Information:

Name of Referrer: _____ Date: _____

Facility: _____ Position: _____

Phone/Fax/Email: _____

5. Other Relevant Information/Remarks:

Baseline/Current

1. Psychiatric Hospitalization (in the past two year): () Yes () No () Never Hospitalized () Unknown

	Episode 1	Episode 2	Episode 3
Admission Date (yyyy/mm/dd)			
Discharge Date			
Estimated period (yyyy/mm) if exact date not available			
Estimated Number of Days			
Name of Hospital			
Reason for Hospitalization			

For Internal Use Only

Assessment

Hong Fook Client Number: _____

*Referral Date: _____
(yyyy/mm/dd)

1. **Service needs identified:

2. **Recommendations by Hong Fook Intake Worker:

- () This client will need regular case management service
- () This client is recommended for priority service

Signature of Intake Worker: _____ Pending Date: _____
(yyyy/mm/dd)

3. Final decision and follow-up actions by Hong Fook staff after screening:

Signature of Senior MHW: _____ Endorsement Date: _____