COMMUNITY RESIDENTIAL PROGRAM REFERRAL

MENTAL HEALTH USE ONLY

CLIENT NUMBER | ASSESSMENT DATE (YYYY MM DD)

1 ☐ NEW ASSESSMENT 2 ☐ REVIEW 3 ☐ REASSESSMENT 4 ☐ APPEAL 5 ☐ CORRECTION

HEALTH DIST. | ASSESSOR

REFERRAL COMPLETED

1 ☐ CLIENT'S HOME 2 ☐ FACILITY 3 ☐ ACUTE HOSPITAL 4 ☐ OTHER

The personal information collected on this form is used for the purpose of assisting the Community Residential Program staff to administer the Community Residential Program and is collected under the authority of the *BC Benefits (Income Assistance) Act, Section 8* and the *Mental Health Act* . Questions about the use and collection of this information can be directed to (e.g. Residential Care Worker, MHC Director)

Name *Title*

Department *Address* *Phone Number*

Use instructions provided to complete this form thoroughly. ***Complete every item.*** ***Where information is unavailable write N/K or N/A***

PERSONAL INFORMATION

FAMILY NAME | FIRST NAME | INITIALS

CURRENT ADDRESS - STREET | TELEPHONE NO. | PREVIOUS 12 MONTHS B.C. RESIDENCY ? ☐ YES ☐ NO

CITY | POSTAL CODE | SEX ☐ M ☐ F | DATE OF BIRTH (YYYY MM DD)

MARITAL STATUS: 1 ☐ SINGLE 2 ☐ MARRIED 3 ☐ WIDOWED 4 ☐ DIVORCED 5 ☐ SEPARATED 6 ☐ OTHER | MEDICAL PLAN NO. | DEP | WR

CAPABILITY STATUS: ☐ INCAPABLE OF FINANCIAL AFFAIRS ☐ INCAPABLE OF THE PERSON

COMMITTEE: ☐ PUBLIC TRUSTEE ☐ SAME AS CONTACT PERSON ☐ OTHER | NAME | TELEPHONE NO. | ADDRESS

INITIALS | TELEPHONE NO. | RELATIONSHIP

STREET ADDRESS | CITY | POSTAL CODE

1. DOES THE CLIENT RECEIVE "GAIN" FOR SENIORS OR "GAIN" FOR HANDICAPPED ?
1 ☐ YES 2 ☐ NO IF YES ➡

IF THE CLIENT IS **65 YEARS OR OLDER** RECORD THE 9 DIGIT NUMBER WHICH APPEARS TO THE RIGHT OF THE THE PAYEES NAME ON THE "GAIN" CHEQUE

IF THE CLIENT IS IS UNDER 65 YEARS OF AGE, RECORD ANY ALPHABETICAL SUFFIX AFTER THE 9 DIGIT NUMBER

START 9 DIGIT NUMBER HERE

PLACE ANY ALPHA SUFFIX HERE

2. IS THE CLIENT IN RECEIPT OF THE GUARANTEED SUPPLEMENT ?
1 ☐ YES 2 ☐ NO

3. IS THE CLIENT IN RECEIPT OF WAR VETERAN'S ALLOWANCE ?
1 ☐ YES 2 ☐ NO

IF THE ANSWER TO 1, 2, 3 IS "NO", IS THERE AN INDICATION OF FINANCIAL NEED FOR FACILITY AND COMFORTS ?
1 ☐ YES 2 ☐ NO

SOURCE OF INCOME
☐ EMPLOYED ☐ GAIN ☐ GAIN HANDICAPPED ☐ OAS/GIS ☐ UIC ☐ DVA ☐ DEPENDENT ☐ PRIVATE PENSION ☐ OTHER

I hereby apply for the benefits for which I/client may be eligible under the Mental Health Services Program and certify that the information I have provided is correct to the best of my knowledge, and may be released to appropriate Mental Health Service Providers to the Mental Health Division, and to:
(name of person)

CLIENT OR AUTHORIZED SIGNATURE

MENTAL HEALTH SERVICES USE ONLY

RECOMMENDED OUTCOME

1 ☐ NOT ELIGIBLE
2 ☐ HOMEMAKER
3 ☐ CARE IN FACILITY
4 ☐ HOME CARE PROGRAM
5 ☐ THIS CODE NOT USED)
6 ☐ DAY CARE

1 ☐ PERSONAL CARE
2 ☐ INTERMEDIATE CARE 1
3 ☐ INTERMEDIATE CARE 2
4 ☐ INTERMEDIATE CARE 3
5 ☐ EXTENDED CARE

RECOMMENDED PROVIDER

RECOMMENDED HOURS/SERVICE

ASSESSOR'S NAME

APPROVAL OF CARE LEVEL AND SERVICES

1 ☐ NOT ELIGIBLE
2 ☐ HOMEMAKER
3 ☐ CARE IN FACILITY
4 ☐ HOME CARE PROGRAM
5 ☐ (THIS CODE NOT USED)
6 ☐ DAY CARE

1 ☐ PERSONAL CARE
2 ☐ INTERMEDIATE CARE 1
3 ☐ INTERMEDIATE CARE 2
4 ☐ INTERMEDIATE CARE 3
5 ☐ EXTENDED CARE

MENTAL HEALTH CENTRE DIRECTOR'S SIGNATURE

DATE

CAUTION SHEET REQUIRED?
☐ YES ☐ NO

ALLERGIES?
see page 3
☐ YES ☐ NO

MENTAL HEALTH SERVICES
COMMUNITY RESIDENTIAL PROGRAM
REFERRAL FORM USER GUIDE

A. PURPOSE OF COMMUNITY RESIDENTIAL PROGRAM REFERRAL

The referral information provided with enable the Community Residential Program staff, to determine if any suitable facilities are available for the client. The Community Residential Program referral form is to be completed by the referring agencies prior to consideration of the client for placement.

If the client is placed in a Community Residential Program facility, the clinical information provided will serve as a basis for treatment planning by Mental Health Services and facility staff. The information will also enable the designated Mental Health Centre staff to recommend and authorize the level of care. Failure to fully complete the referral form may result in a delay in placement.

B. INSTRUCTIONS FOR COMPLETING THE COMMUNITY RESIDENTIAL PROGRAM REFERRAL

Page 1 Client # (MH USE ONLY)
Contact local LTC officers for any previous registration # and enter on form. If no previous # exists, leave this section blank and MH will assign a new # to the client.

Page 1 Assessment Date (MH USE ONLY)
Enter date on which MH staff recommended a level of care or other service.

Page 1 Level of Assessment (MH USE ONLY)
Check off appropriate box:

- **(a) New Assessment** Where no previous LTC client # exists, the completed referral represents a new assessment.
- **(b) Review** A review is an assessment of a resident's care needs and care plan which may lead to a re-assessment of a resident's care level classification.
- **(c) Re-Assessment** A re-assessment is a formal assessment of the level of care of a resident which may result in a change in the resident's care level classification.
- **(d) Appeal** Service Provider disagrees with the assessment of a resident's care level.
- **(e) Correction**

Page 1 Health District (MH USE ONLY)
Enter health district # of the catchment area where client is to be placed. This shall be completed by the Mental Health Centre Director at the time of care level authorization.

Page 1 Assessor # (MH USE ONLY)
Enter full 6 digit number of the MH assessor recommending the level of care.

Page 1 Family Name
Include any other known name/alias on separate sheet (addendum).

Page 1 BC Residency
Client must be a resident of BC for preceding 12 months or have an approved residency waiver in order to be eligible for Community Residential placement.

Page 1 W/R
Indicate a "W" for those persons receiving social assistance benefits. The "R" should be used for those persons not receiving social assistance benefits.

Page 1 Capability Status
This is a legally determined status and is made under the *Patients Property Act*. This information may be found in the patient record or obtained from the attending psychiatrist, the client or family members.

Page 1 Committees
A committee is the person legally designated to make decisions for another, either in regard to their finances (property) or their person, or both.

Page 1 Caution Sheet (MH use only)
Mark "Yes" if there has ever been a Caution Sheet completed. Use Caution Sheet as indicated in the MHS Clinical Policies and Procedures manual. Any information on the Caution Sheet **must** be included in the referral form information.

Page 1 Allergies (MH use only)
Indicate if any known drug, food or environmental allergies exist. See allergy information section on page 3 of referral form.

Page 2 Educational/Vocational, Employment History
Indicate all post-secondary education. If N/A, then note last grade completed.
Indicate all vocational training. List all positions of employment and indicate the years positions held, i.e. 1974-76, or 3 months in 1980.

Page 2 Hobbies/Interests, Special Abilities
"Special abilities" refers to playing of musical instruments, computer skills, artistic or athletic talents, etc. Include activities client would like to do.

Page 3 Psychiatric Diagnosis
Use DSM III terminology, if available.

Page 3 Degree of Mental Handicap (Retardation)
Indicate IQ level where information available and/or the level of handicap, i.e. profound, moderate, mild, borderline.

Page 3 Alcohol/Drugs
Indicate whether alcohol or drugs previously or currently interfere(d) with client's daily functioning.
Smoking: Indicate excessive or unsafe smoking habits.

Page 3 Allergies
Indicate if any food, drug or environmental allergy exists.

Page 3 Stressful Situations
This could include stressful circumstances in the following areas: interpersonal relationships, finances, social skills, physical illness, housing, employment, education, etc.

Page 3 Traumatic Events
Describe traumatic events in client's life. For example, sexual/physical abuse, rapes, deaths, etc.

Page 3 Decompensation
Describe signs of decompensation with regard to the areas of behaviour, personal hygiene, speech, thought content and changes in mood.
For example: deterioration in personal hygiene, aggressive behaviour, hostility, compulsiveness, withdrawal, retarded or pressured speech, delusions, hallucinations (auditory/visual), depressed or euphoric mood. Be specific in describing the signs of decompensation.

Page 4 Problem Reference, List (Back of User Guide)
Read directions on the Problem Reference List. The list is intended to be used as a reference guide, but may also be used as a checklist if desired. In the latter case, the list may be retained in the client record. If used for this purpose, each page must have client identification and date of completion. This list is intended to assist in the completion of the referral form and is **not** for distribution to service providers.

Page 5 Strengths
Indicate positive personality traits and interpersonal strengths.
For example: reliable, dependable, honest, kind, considerate, compassionate, generous, neat, tidy, clean, works well in groups, self disciplined, perseverant, insightful, punctual, problem solving skills, tolerant, outgoing, sociable, perceptive, workmanlike, courteous, trustworthy, responsible, pleasant, agreeable, stick-to-itiveness, stamina, patience, constancy, charming, persistent, gracious, plucky, etc.

Page 5 Goals of Residential Placement
Indicate purpose and goals of residential placement. State short and long term goals in objective, behaviourally measurable terms.

Page 5 Summary
This space is available for additional comments or a summary statement.