Ontario Health atHome

Mental Health & Addiction Nurse (MHAN) School Program - Referral Form

*** All sections must be completed - incomplete forms will be faxed back to the referral source ***

Student's last name:	Student's first name: Preferred name:
Gender Identity: ☐ Male ☐ Female ☐ Intersexed ☐ Two Spirit ☐ Transgender ☐ Genderqueer ☐ Prefer Not to Answer ☐ Do Not Know ☐ Other What sex were you assigned at birth (i.e. on your birth certificate ☐ Female ☐ Male ☐ Prefer Not to Answer ☐ Do Not Know ☐ Other What are your preferred pronouns?	Parent/Guardian name: Relationship to student: Address (if different from student): Phone: / / Other custodial Parent name: Relationship to student: Address (if different from student): Phone: / /
Student's address: City/Town: Postal Code:	DOB (DD/MM/YYYY): Age:
Preferred method to contact student: ☐ Home phone: / / ☐ Cell phone: / / ☐ Other: / / ☐ At school: / /	
Identified Aboriginal status: ☐ Y ☐ N If yes, Band #/Patient's band #:	
Languages Spoken in Home (Maternal Tongue): ☐ English ☐ French ☐ Indigenous ☐ Other: Interpreter Required? ☐ N ☐ Y Specify:	
School board:	Grade of student:
School name: City/Town:	School phone: / / School fax: / /
Name of Primary Care Provider (NP/MD):	
List students current mental health and/or addiction community agency(s) involvement: Name of agency: Name of contact at agency: Contact number: / /	Name of agency: Name of contact at agency: Contact number: / /

Information Provided for Referral (if available):

☐ Case Summary
☐ Education Assessment
☐ Psychological Assessment
☐ Previous Psychological Consultatives
☐ Individual Education Plan (IEP)
☐ Safety/Interaction Plan
☐ Most recent report card
☐ Other _____

Presenting concern:

_____

_____

_____

_____

Reason for referral (Check all that apply):

- ☐ Medication concerns (side effects, med changes, discontinuing)
- ☐ Symptoms of Depression
- ☐ Symptoms of Anxiety
- ☐ Mood Disorder
- ☐ Acute Self-harm
- ☐ Suicidal ideation
- ☐ Homicidal ideation or intent
- ☐ Paranoia/Delusions
- ☐ Psychiatric Hospitalization
- ☐ Substance use/abuse
- ☐ Unpredictable/disorganized speech and thoughts
- ☐ Innatention/Hyperactivity
- ☐ Eating disorders (obsessive diet patterns, other)
- ☐ Other **medical** condition that is contributing to a change in mental health status: _____

MHAN School Program requires verbal consent from ALL students to be seen by MHAN and parent / guardian consent for any student less than 12 years of age.

Date verbal consent for referral to MHAN services obtained from student: _____

Date parent/guardian consent for referral to MHAN services obtained: _____

Referral source and relationship to patient: _____

Contact Number: _____

Signature of referral source: _____ Date (DD/MM/YYYY): _____

MHAN will attempt to provide a response within seven business days of receiving referral and if appropriate, follow up with the student and/or parent/guardian.

_____	_____	_____
Student's Ontario HCN	VC	Expiry date

Please FAX referral to 807-346-4484**This is a legal document and is not to be altered*