Ontario Health atHome

# MENTAL HEALTH AND ADDICTIONS NURSING PROGRAM (MHAN)

FAX: (519) 571-3957

Legal name (as it appears on Health Card): ________________________ Preferred Name: ________________

HCN: ________________________ VC: ________ DOB (dd/mm/yyyy): ________________

Gender: ☐ Male ☐ Female Gender Identity: ________________ Pronouns used: ____________

Does student self-identify as having First Nations (status or non-status), Métis, or Inuit ancestry? Yes ☐ No ☐

Preferred language: ☐ English ☐ French Other: ______________ Interpreter Required Yes ☐ No ☐

Home Address: ________________________ City: ______________ Postal Code: __________

Student's Cell Ph: ________________ Home phone: ________________________

Family Doctor: ________________Community Psychiatrist: ________________

☐ Student is in the Care of Children's Aid Society (Child's Aid Society is student's legal guardian)

Protection Agency and Worker: ________________ Contact: ________________________

**Parent, Guardian or Other Contact Information *ONLY list contacts student has consented for MH nurse to speak with.**

☐ Mother ☐ Father ☐ Other ☐ Emergency Contact only

Name: ________________________

Home ph: ____________ Cell ph: ____________

Address: ________________________

City: ____________ Postal Code __________

☐ Mother ☐ Father ☐ Other ☐ Emergency Contact only

Name: ________________________

Home ph: ____________ Cell ph: ____________

Address: ________________________

City: ____________ Postal Code __________

**Consent for Referral to Child/Youth MH (MHAN) program**

Verbal Consent obtained from: ☐ Student Date:______________ ☐ Parent Date:______________

School enrolled: ________________ City: ______________ Ph: ______________

☐ I give permission to the MHAN program nurse to collect information for the purpose of providing care/services, to share that information with those in the circle of care, and to notify/speak to my school that I am participating in the MHAN program. No other information will be shared with my school or others without my informed consent.

**Health Information** ☐ Presenting MH Concerns: ________________________

☐ Allergies: ________________ ☐ Community Agencies: ________________

**Risk Factors** ☐ Suicidal Ideation/attempts ☐ Passive ☐ Active ☐ Historical specify: ____________

☐ Relevant Family MH history/stressors specify: ________________________

Safety Concerns in home ☐ Firearms ☐ Weapons ☐ Smoking ☐ Pets specify: ________________

☐ Nicotine/Vaping ☐ Alcohol ☐ Substance Use ☐ Addiction concerns specify: ______________

**Mental Health Nursing Role Needs of Student**

☐ Medication changes/side effects ☐ Medication Education Medication list: ________________

☐ Health Teaching (Nutrition, Physical Activity etc.) ☐ Sleep hygiene ☐ Transition from Hospital

☐ MH Health System Navigation ☐ Other specify: ________________________

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**Patient History/Pertinent Information** *Please attach any relevant Medical History, Medication list and Collateral information

There may be times when referrers are unsure of whether a student meets the eligibility criteria, in these times, reach out to (519) 748-2222 ext. 2007 to be re-directed to a Mental Health & Addiction's nurse to discuss further.

**REFERER** ☐ Inpatient Hospital: ______________________ Discharge Date: ____________ ☐ Outpatient Clinic: __________

Designation: ☐ Hospital Staff (Nurse, OT, SW) ☐ Psychiatrist ☐ Family Physician ☐ Pediatrician ☐ Community Partner

Referrer Name: ________________________________________ Signature: ________________________________________

Contact info: ___________________________________________ Date: ___________________________________________

*Only complete section below, if you are referring to MHAN program from a school and/or school board

**SCHOOL BOARD REFERRER** SW, CYW, Psychologist at one of the following school boards:

☐ UGDSB ☐ Wellington Catholic ☐ WRDSB ☐ WCDSB ☐ Private/Online learning

Referrer Name: ____________________________________________Signature: ________________________________________

Contact info/ext.: ___________________________________________ Date: ___________________________________________

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**A MH nurse will connect with student, parent and/or guardian to confirm consent and finalize eligibility.**