Ontario Health atHome

Referral – Mental Health and Addiction Nursing Program

Student information

Last Name: ______ First Name: ______

Pronoun: ______ HCN: ______ D.O.B.: ______ Grade: ______

Home Address: ______ City: ______ Postal: ______

Preferred Student Contact Number: ______

Physician and Family

Physician involved Name: ______ Contact Number: ______

PRIMARY CONTACT:	**SECOND CONTACT:**
Mother Father Guardian **Ok to contact:** Yes **N**o	Mother Father Guardian **Ok to contact:** Yes **N**o
Name: ______	Name: ______
Home: ______	Home: ______
Cell: ______	Cell: ______
E-mail: ______	E-mail: ______

Custody arrangements/orders: (both signatures required in joint custody agreements)

Consent

Date Consent obtained from: Student: (D/M/Y) ______

Date Consent obtained from: Parent Guardian: (D/M/Y) ______

Reason for Referral: (Detailed referral information is required)

Anxiety Self Harm Substance Use Disordered Eating

Depression Suicidal thoughts Medication Change Other

Please explain:

What is the desired outcome of MHAN involvement: ______

Previous counselling / interventions prior to referral and the outcome :

List any current active community mental health counselling/supports:

Teacher & School & School Board

School Contact (please print) Title

Signature Date: (D/M/Y)

Please FAX Completed Referral to: Ontario Health atHome School Health Support Services Team VIP Fax Line: **Toll Free 1-844-800-4578**
Ontario Health atHome School Health Support Services Team VIP Line: **Toll Free 1-877-900-5667**
An Ontario Health atHome MHAN will contact the student or parent/guardian to determine/confirm consent for appropriate referrals.