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:
Mother Father Guardian **Ok to contact:** Yes **N**o

SECOND CONTACT:
Mother Father Guardian **Ok to contact:** Yes **N**o

Name: ....
Home: ....
Cell: ....
E-mail: ....

Name: ....
Home: ....
Cell: ....
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.