Ontario Health atHome

MENTAL HEALTH AND ADDICTIONS NURSING PROGRAM (MHAN)

FAX: (519) 571-3957

Legal name on Health Card (HCN): _____ 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: _____

Home Phone: _____ Student's Cell: _____

Family Doctor: _____ Psychiatrist: _____

☐ Community Agencies involved: _____

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

Protection Agency and Worker: _____ Contact: _____

Contact Information

☐ Mother ☐ Father ☐ Guardian *Ok to contact Yes ☐ No ☐

Name: _____

Home phone: _____ Cell: _____

Address: _____

City: _____ Postal Code _____

☐ Mother ☐ Father ☐ Guardian *Ok to contact Yes ☐ No ☐

Name: _____

Home phone: _____ Cell: _____

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: _____

Health Information

☐ Presenting MH Concerns: _____

Medication List: _____ ☐ Attached Medical List

☐ Allergies: _____ ☐ Suicidal Ideation/attempts ☐ Passive ☐ Active ☐ Historical

☐ Relevant Family MH history/stressors specify: _____

Risk Factors

Safety Concerns in home ☐ Firearms ☐ Weapons ☐ Pets specify: _____

Addictions: ☐ Nicotine/Vaping ☐ Alcohol ☐ Marijuana ☐ Other specify: _____

Mental Health Nursing Role Needs of Student

☐ Medication changes/side effects ☐ Medication Education ☐ Addictions support ☐ MH Health System Navigation

☐ Health Teaching (Nutrition, Physical Activity, Sleep Hygiene) ☐ Transition from Hospital ☐ Other specify: _____

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

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.

REFERRER ☐ Inpatient Hospital: _____ Discharge Date: _____ ☐ Outpatient Clinic: _____

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

Referrer Name: _____ Signature: _____

Contact info: _____ Date: _____

*Section below, is for MHAN referrals from a school and/or school board

SCHOOL BOARD REFERRER at the following school boards:

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

Referrer Name: _____ Signature: _____ Date: _____

Contact #: _____ Ext: _____ Email: _____

Ontario Health atHome Child and Youth Mental Health & Addictions Nursing Program
Fax: 1 (519) 571-3957
A MH nurse will connect with student, parent and/or guardian to confirm consent and finalize eligibility.