Ontario Health atHome

Mental Health & Addiction Nurse (MHAN) Referral Form

Please ensure form is completed for accuracy. Fax completed form to 1-855-787-4838

School Information		
School board: Choose an item	School name:	Grade:
School address:		City:
School contact name:		Phone #

To be eligible to receive Ontario Health atHome MHAN services the student must be:

- ✓ A Registered student (up to age 21) *(can include home instruction)*
- ✓ In need of services or related treatment to an identified and/or suspected mental health and/or addictions issue
- ✓ Aware and have consented to the referral

***Note**: See page 2 for additional eligibility and referral information.*

Patient Information		
Legal name (Last, First):		
HCN:	VC:	DOB:
Preferred name:	Sex:	Identifies as:
Address:		City:
Postal code:	Contact #	Student cell #
Preferred language:	Interpreter required: ☐ Yes ☐ No	
Allergies:		
Primary care provider (Physician/NP):		Phone #

Relevant Contacts					
☐ Parent 1	☐ Parent 2	☐ Guardian	☐ Parent 1	☐ Parent 2	☐ Guardian
Name:			Name:		
Relationship:			Relationship:		
Home #			Home #		
Cell/alternative #			Cell/alternative #		

Referral Information *(verbal consent required from student and/or legal decision maker)*	
Verbal consent for referral obtained from student: ☐ Yes ☐ No	On this date:
Verbal consent to contact the student at school: ☐ Yes ☐ No	On this date:
Verbal consent for referral obtained from parent/guardian: ☐ Yes ☐ No	On this date:
Previous mental health diagnosis: ☐ Yes ☐ No; Describe:	

Reason for Referral *(select all that apply)*: ☐ System navigation; ☐ School avoidance with student's intent to return; ☐ Early ID and intervention for mental health and addictions; ☐ Medication management; ☐ Health teaching; ☐ Family support; ☐ Safety planning; ☐ Healthy coping skills development; ☐ Other:_____

Describe reason for referral: ☐ *Additional Information Page 3*

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Legal name (Last, First):	HCN:

Addiction concern(s): ☐ Yes ☐ No; Describe:				
Mental health concern(s): ☐ Yes ☐ No	☐ Anxiety	☐ Depression	☐ Mood dysregulation	☐ Withdrawn
☐ Risk to self	☐ Risk to others	☐ Eating disorder/concerns		
Changes in behaviour: ☐ Yes ☐ No	Describe:			
Other agencies involved with student:				

Patient History

Recent hospital visit: ☐ Yes ☐ No	ED visit:	Discharge date:
Medications *(include name, dose and frequency)*:		
Pre-existing medical condition(s):		
Additional information (Consult notes, best possible medication history, etc.) relevant to referral: ☐ *Additional information attached (Page 3)*		

Referral Source

Name:	Contact #
Organization:	Date:
Email address:	Signature: _____

Mental Health and Addictions services provided by the MHAN may include:

- System navigation.
- Early identification and intervention for both mental health and addictions.
- Reengagement of students displaying school avoidance behaviours.
- Working with an inter-disciplinary school board team and other professionals to provide mental health and addictions services and supports to students and their families.
- Follow-up with students released from hospitals, emergency departments, and other sectors for mental health and addictions issues.
- Medication review and reconciliation.

Exclusion criteria typically includes the following:

- When the focus of intervention is behaviour modification in absence of mental health and/or addiction issue.
- Students who refuse or do not consent to the services of the MHAN program.
- Students who are not attending school with no intention to return.

Exceptional Circumstances:

- Students on the Autism spectrum considered only for safety planning and/or system navigation working in collaboration with existing team.
- There may be times when referrers are unsure of whether a student meets the eligibility criteria for referral to the MHAN program, in these times – reach out to your local MHAN team to discuss at 1-800-263-3877 x 5814.

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Legal name (Last, First):	HCN:

Additional Information: