



200 Terrace Hill Street
E-Wing, Main Floor
Brantford, Ontario
N3R 1G9

519-751-5530 ext. 2567

Acute Day Treatment (ADT) Program

*** Physician or Nurse Practitioner (NP) - Follow up required.**

Date: _____ Referring Agency: _____

Referring Name: _____ Phone: _____

FAX Referrals: 519-752-7146

Email: mhreferrals@bchsys.org

Please complete fully including the route to reach you with questions.

Client Last Name _____ Client First Name _____ Client Middle Name _____

Address (Street #) _____ City/Province _____ Postal Code _____ Phone Number(s) _____

Gender Identity (Preferred Pronoun) _____ Date of Birth (DD/MM/YYYY) _____ Age _____

Email Address (Recommended) _____ OHIP # including Version Code _____

Allergies _____ Other Medical Issues (asthma, diabetes. etc.) _____

Next of Kin Name or Emergency Contact _____ Address _____

Phone Number _____ Relationship to Client _____

Interested in/ prefer Indigenous centered Counselling? Yes No Interpreter required? Yes No

Can a confidential message be left on voicemail? Yes No Client aware of/agrees with referral? Yes No

Is the client already seeing a BCHS counsellor? Yes No
(If yes, please do not refer until counselling is closed)

Primary Care Provider: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Pharmacy: _____ Phone: _____

Client Initials: _____

Reason for Referral: Please check the following area(s) of concern that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> Neurodevelopmental Disorder (ADHD, autism, etc.) | <input type="checkbox"/> Compulsive behaviours | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Delusions/ Paranoia | <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Gender dysphoria |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Grief reaction | <input type="checkbox"/> Impulse control |
| <input type="checkbox"/> Psychosis | <input type="checkbox"/> Problematic substance use | <input type="checkbox"/> Personality related |
| <input type="checkbox"/> Elevated mood | <input type="checkbox"/> Stress | <input type="checkbox"/> Mood instability |
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Trauma | <input type="checkbox"/> Self-injury/self-harm |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Dissociation | <input type="checkbox"/> Suicidality |
| | <input type="checkbox"/> Somatic symptoms | <input type="checkbox"/> Other mental health symptoms |

Please share clients goals for Program (Required):

Current Risk: (High/Moderate/Low) Harm to Self _____ Harm to Others _____

We respond promptly but not immediately to referrals. If risk level warrants, please access Emergency Services. More details/other concerns:

If this section is left blank, we are assuming that the risk is low.

Primary Concern, Medication, and Other Relevant Information:

(Including reason for referral, involvement with other services/counselling, eligibility for EAP, medications). (Attach relevant documents).

Criteria:

- | | |
|---|--|
| <input type="checkbox"/> Client is medically stable | <input type="checkbox"/> Client prefers IN-PERSON care |
| <input type="checkbox"/> Client has capacity to attend program 5 days per week for 6 weeks | OR |
| <input type="checkbox"/> Client is able to personally manage level of risk outside of program hours | <input type="checkbox"/> Client prefers HYBRID care |
| <input type="checkbox"/> Client has goals related to mental health (not only socialization) | |
| <input type="checkbox"/> Client has not completed Acute Day Treatment (ADT) in the past year | |

Internal Use

Appointment Date: _____ Time: _____ Counsellor: _____