



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

**519-751-5530 ext. 2567**

# Acute Day Treatment (ADT) Program

**\* General Practitioner (GP) or Nurse Practitioner (NP) Referrals Only - Follow up not required.**

Date: \_\_\_\_\_ Referring Agency: \_\_\_\_\_

Referring Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**FAX Referrals: 519-752-7146**

**Email: [mhreferrals@bchsys.org](mailto: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 \_\_\_\_\_ 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)

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Psychiatrist: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

**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):**

**Medications:**

**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          | <input type="checkbox"/> Client prefers HYBRID care    |
| <input type="checkbox"/> Client is able to personally manage level of risk outside of program hours |  |
| <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: \_\_\_\_\_