SASHA
TRANSFORMATIVE MENTAL HEALTH SUPPORT

REFERRAL PACKAGE

Client Information

CLIENT Name: ____ **Gender:** ________ **PHN #** ______________________

Birth Date: _____________________ **Current Address**: ____ **Unit #:**_______

City/Town: _____________________ **Postal Code**: ____________ **Client Phone #:** ___________________ **Alternate Phone #:**__________________

Psychiatrist: ____________________ **Phone #:** ____________________**Physician**: _____________________________**Phone #:** _________________

Mental Health Therapist/ Case Manager: _________________________________**Phone:** ______________________________

STATUS: Independent ☐ Guardianship ☐ Trusteeship ☐ Personal Directive ☐ (attach personal directive or id. location) ___________________________

Primary/Emergency Contact: NAME: _________________________________ **Phone #:** ______________________ **Relationship:**______________________

Referral Source Information

Referral Source: ____________________________________ Referral Contact Name: _________________________________

Referral Contact Phone #: _____________________________ Date requesting housing: _______________________________

Placement Information

Program Placement Required:

☐ **Type of Placement Required:** Respite Transitional Long Term Is the client on a CTO: Yes No Is the client housing first: Yes No

Why are you requesting this placement? ____

☐ **Client source of income:** Employment ☐ Social Assistance ☐ Pension ☐ AISH ☐ Other (describe): ___________________________________

Ethical, Spiritual or Cultural Considerations for Client Care:

____

PERSONAL HEALTH INFORMATION

	Comments:
Mental Health Diagnosis	
Current/Previous Substance Use	
High Risk Behavior Concerns	
Physical Health Concerns/Conditions	
Allergies	
Current/Present Legal Issues	

Has a summary of Mental Status or Psychiatric Assessments been included attached to this referral? Yes_______ No_______

Has the clients Current Medication List been included attached to this referral? Yes_________ No________

MENTAL HEALTH / COGNITION CLIENT INFORMATION

CLIENT Name: ____________________ Assessment Date: ________________________

Please comment on the following areas with respect to how it affects client functioning and independence.

Client Functioning:

Memory:

____

____

Decision-Making/Impulse Control:

____

____

Appropriate Social Interaction Behaviors:

____

____

Inappropriate Social Interaction Behaviors:

____

____

Communication/Comprehension Skills:

____

____

Emotional regulation:

____

____

Symptoms/Symptom Management Skills:

____

____

Addition Relevant/General Information or Comments:

____

____

____

____

____

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INDIVIDUAL SERVICE PLAN (ISP) CONSIDERATIONS:

Client Name: ___________________________________

CLIENT requires additional support in the following areas identified: **Support requirements/expectations include but are not limited to:**	**Yes/No/N/A as appropriate**	**Additional Comments Around Client Support Needs:**
A. Assistance maintaining communication with the clients **Treatment Team/Community Resources** to insure continuity of care.	☐ Yes ☐ No ☐ N/A	
B. Assistance developing knowledge and building on client's **Independent Living Skills. (Chores, Meal Preparation ETC.)**	☐ Yes ☐ No ☐ N/A	
C. Assistance in **maintaining or improving a holistic health regimen** (i.e. general physical/mental health, dental hygeine, diet and overall well-being).	☐ Yes ☐ No ☐ N/A	
D. Assistance in **maintaining and/or improving hygiene behaviors**.	☐ Yes ☐ No ☐ N/A	
E. Assistance with and education around the importance of **clean and seasonally appropriate clothing**.	☐ Yes ☐ No ☐ N/A	
F. Assistance with finding and attending **appropriate meaningful daily activity that will assist the client in adapting new skills.**	☐ Yes ☐ No ☐ N/A	
G. Assistance with developing appropriate **time management skills.**	☐ Yes ☐ No ☐ N/A	
H. Assistance to improve **money management skills** (i.e. budgeting, banking, payment of bills, etc.).	☐ Yes ☐ No ☐ N/A	
I. Assistance with and education about the importance of **leisure and recreational** activities.	☐ Yes ☐ No ☐ N/A	
J. Assistance acquiring knowledge of, and/or use of **community resources (i.e. bus routes, mental health organizations, banks, church, and recreational services** etc.).	☐ Yes ☐ No ☐ N/A	
K. Assistance with building **Meaningful Community Relationships** to encourage independent behaviors.	☐ Yes ☐ No ☐ N/A	
L. Assistance **Monitoring Medication Compliance** according to policy and under the direction of the Case Manager as outlined in the clients ISP.	☐ Yes ☐ No ☐ N/A	
M. Assistance accessing **personal identification services.** (I.e. Alberta I.D. program)	☐ Yes ☐ No ☐ N/A	
N. Assistance dealing with **current/past legal issues** and connecting the client to available legal resources.	☐ Yes ☐ No ☐ N/A	
O. Assistance in **locating suitable accommodations, acquiring furnishings, setting up moving assistance, and providing information on community resources,** which will assist the client in functioning independently and successfully in the community.	☐ Yes ☐ No ☐ N/A	

Client's Main Goals for Support:

____

Client Signature: _____________________________ **Referral Signature:** ___________________________

CONSENT TO DISCLOSE
PERSONAL INFORMATION

CONSENT TO DISCLOSE PERSONAL INFORMATION

FOR INDIVIDUAL

I, ______________________________ of ______________________________
(Name of client/patient and date of birth – please print) (Address)

Give consent to the staff of ______________________ to disclose the following health information (list specifically
(Name of service provider – facility, clinic, agency, service contractor or committee)

What information is to be disclosed): ______________________________

____

To: ______________________________
(Name of service provider - agency)

FOR SUBSTITUTE DECISION-MAKER

I, ______________________________, the ______________________________ on behalf of
(Name of substitute decision-maker – please print) (Identify legal status, e.g. parent/guardian/agent)

______________________________ give consent to staff of ______________________________
(Name and date of birth of client/patient – please print) (Name of service provider – faculty, clinic, agency, service contractor or committee)

____

To disclose the following information (list specifically what information is to be disclosed): ______________________________

____

To: ______________________________
(Name of service provider – agency)

I understand the reason for disclosing this information is: ______________________________

____

I confirm that I was told why the information is needed and the risks and benefits to ______________________ of consenting to disclose or refusing to disclose the information.

I also confirm that I was told and understand that I may cancel this consent in writing at any time, and no further information would be disclosed unless required by law.

CONSENT TO DISCLOSE PERSONAL INFORMATION Continued...

This consent is effective from the ______________________________ day of __________________________, 20___, until

____________________________ day of ____________________________ 20_______

(Recommended standard is 90 days.)

____

(Signature of client or substitute decision-maker) Date

____

(Name of witness – please print) (Signature of witness)

A photocopy or facsimile signed by the individual/substitute decision-maker is deemed as valid as the original.

I understand that the reason for collecting and releasing this information is: to access services and for treatment purposes only, and that I am free to withdraw consent at any time and must do so in writing. If I choose to cancel consent for any or all of the above persons and/or agencies, no further information will be collected or disclosed with them unless required by law. I have been advised that withdrawing consent may impact the ability of SASHA staff to provide me with support, and may also impact my placement in the SASHA program.