Canadian Mental Health Association
Huron Perth
Mental health for all

Association Canadienne pour la santé mentale
Huron Perth
La santé mentale pour tous

Our Vision: A society that values human dignity and enhances mental and emotional wellbeing for all.

CMHA-HP / Community Homes for Opportunity Program
Resident Referral and Assessment Form

Name _____S.I.N. # _____
Current Place of Residence: _____
Date of Birth _____ Place of Birth _____Certificate
Marital Status _____Sex_____
Languages Other Than English _____ Religion _____

Source of Income _____ ODSP # (If Applicable) _____
Substitute Decision Treatment Finance Name: _____
Public Trustee File #_____

Health Card #: _____ Card Expiry Date _____

Next of Kin: _____ Relationship _____
Address: _____ Telephone _____
Family: _____
_____
Name of Referring Source: _____ Telephone _____

Physical Health

Health Problems: (Ex. Epilepsy, Diabetes, Heart Disease, Stroke, Surgery, Infections, Etc.)
Yes No
_____
_____

Physical Handicaps: (Ex. Deformities, Amputations, Prosthesis, Mobility Issues)
Yes No
_____
_____

Allergies: Yes No

Medication: _____
Food: _____

Mental Health

Orientation: Intact Impaired
Time
Place
Person

Memory: Intact Impaired
Immediate
Recent

Remote
Hallucinations: Yes No

What are these like? How often do they occur? How do you deal with these?

Concentration: Good Fair Poor

	No	Yes	If Yes Describe
Obsessions & Compulsions			
Phobias			
Hypochondriacal Symptoms			
Past Suicide Attempts			
Verbalized thoughts of Suicide			
Self-Harm – Past Attempts			
Verbalizes thoughts of Self -Harm			
History of Aggression			
Verbalizes thoughts of Aggression			
History of Sexual Harm to Others			
Verbalizes thoughts of Sexual Harm to Others			
History of Fire Setting			
Delusions			
Depression			
Difficulties with the Law			
History of non-compliance with medication			

Substance abuse issues

_____

Please indicate signs that person may be becoming ill.

Please indicate any techniques in dealing with person that may be helpful.

Activities of Daily Living

Activity:	Dependent	Independent	Supervision	Assistance	
Oral Hygiene/General Daily Grooming					
Bathing					
Dressing Self					
Toileting					
Feeding					
Laundry					

Incontinence Yes No

Sleep Difficulties Yes No

To Be Accompanied when in Community: Yes No
Specify level of supervision and reason:

Attach additional information:	**1) Copy of Care Plan**	**2) Current Medications**
	3) Social History	

I have explained the Community Homes for Opportunity Program to the applicant and I feel that he/she is an appropriate candidate. It is understood that should the applicant be accepted into the CHO Program, I will be expected to continue to be involved in a consultative role.

Signature: _____ Date: _____
year/month/day

I have discussed the Community Homes for Opportunity Program with my worker and my physician. I understand and agree to abide by the rules and regulations of the program.

Signature: _____ Date: _____
year/month/day

Canadian Mental Health Association
Huron Perth
Mental health for all

Association Canadienne pour la santé mentale
Huron Perth
La santé mentale pour tous

Our Vision: A society that values human dignity and enhances mental and emotional wellbeing for all.

To be completed by CHO Program Staff

The applicant was accepted Yes No

If not accepted, specify reasons why Date: _____
year/month/day

If accepted, address of Home: Client # _____

Name of Worker Date of Placement

Date of Discharge from CHO Program: _____
year/month/day

Discharge Address of Client: _____
_____
_____
_____

Additional Information: _____
_____
_____
_____
_____
_____
_____
_____

CHO Referral Form
Physician to Complete This Page

Medical Report & Discharge Summary

Name of Patient _____

A. Axis I _____

B. Axis II _____

C. Axis III _____

D Axis VI _____

Systemic Conditions: (Indicate applicable item and specify below)

Seizures Dysphagia Dysarthria Aphasia Dysuria Hemorrhoids
Polyuria Diabetes Dyspnea Hernia Cardiac Failure Emphysema
Arthritis Neurological Deficit

Remarks:

_____

_____

Family Physician: _____
Date of last physical examination: _____

Psychiatrist: _____
Date of last psychiatric appointment: _____

Optometrist: _____
Last Examination Date: _____

Dentist: _____
Last Examination Date: _____

Please attach current list of medications (Mar sheet)

Signature of Staff Physician: _____
Date: _____

Print Staff Physician Name: _____
Phone: _____

Please Include/ attach any pertinent information or documents.