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

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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: _____
_____
_____
_____
_____
_____
_____
_____

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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.