



CANADIAN MENTAL
HEALTH ASSOCIATION
ASSOCIATION CANADIENNE
POUR LA SANTÉ MENTALE

Toronto Branch

Mood and Psychosis Early Intervention Program Application for Service

living working belonging

Living, Working, Belonging....this is our goal at CMHA Toronto for all our clients.
Every day our teams provide the supports and services that our clients need so that they can:
Live in the community, in clean, safe affordable accommodation
Work in the community, in paid employment or volunteer activities
Belong in the community, as engaged, valued and contributing members



Mood & Psychosis Early Intervention Program

Mood & Psychosis Early Intervention Program (MOD) provides services to youth who are experiencing what may be the early signs and symptoms of psychosis. The program, which is recovery focused, works to promote early identification and treatment of psychosis, and to help clients achieve their goals at work, at school and with their social networks, thereby minimizing the impact of the psychosis. Services include assessment, the provision and coordination of treatment, education, case management, support and referrals to other services in the community by a multi-disciplinary team including a psychiatrist, nurses, social workers and occupational therapists. The program, which has a specialization in psychosis and mood disorders, also works closely with clients' families, providing them with education and supportive counselling.

Who are Early Intervention Services for?

- Individuals between the ages of 16 and 34
- Individuals presenting to mental health services for the first time with psychosis
- Individuals who have not yet received treatment for psychosis, or who have had less than one year of treatment for psychosis from other mental health services
- Services are available to residents of the City of Toronto living between Victoria Park Avenue and Islington Avenue, and Finch Avenue and Lake Ontario

We Are NOT able to Provide Service To:

- individuals seeking treatment psychotherapy as the primary mode of treatment
- individuals with primary substance abuse disorder
- individuals with a primary anxiety disorder or eating disorder

How do you apply for Early Intervention Services? please forward the referral package, consent forms and supporting documents to:

CMHA Toronto Branch
480-700 Lawrence Ave West
Toronto, Ontario M6A 3B4
Tel: (416) 289-6880
Fax: (416) 289-4306

Date of Referral (day/month/year)

Referring Source

Name; Address (incl. Postal Code): Tel #: Fax #: 6-Digit OHIP Billing #	Referral Type <input type="checkbox"/> Client <input type="checkbox"/> Family <input type="checkbox"/> Physician <input type="checkbox"/> Other (specify)
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Patient Information (Patient must be aged 16-34)

Name; Address (incl. Postal Code): Home #: _____ Messages can be left. <input type="checkbox"/> Yes <input type="checkbox"/> No Work #: _____ Messages can be left. <input type="checkbox"/> Yes <input type="checkbox"/> No	First language: _____ Linguistic/cultural Interpreter Required? <input type="checkbox"/> No <input type="checkbox"/> Yes (specify)		
With the permission of the applicant, is there an alternate contact name in the event we are unable to reach the applicant? Name: _____ Phone Number: _____ Relationship to applicant: _____			
Health Card # and Version Code	DOB (day/month/year)	Age (16-34)	Sex <input type="checkbox"/> M <input type="checkbox"/> F

Reason for Referral:

Has this referral been discussed with the client? Yes No

Is the client in agreement with this referral? Yes No

Is the client competent to consent to treatment? Yes No

Length of time the applicant has been experiencing psychosis? _____

Length of time the applicant has received treatment? _____

Working Diagnosis: Psychosis Affective psychosis

History, symptoms:

HOSPITALIZATIONS (List hospitalizations, related to your mental health problem / psychiatric disability)

ADMIT DATE	HOSPITAL	LENGTH of STAY	REASON(s) for ADMISSION

****If more space is required, please add to back of page**

CURRENT MEDICATIONS (Psychiatric and Non-Psychiatric)

MEDICATION	DOSE / FREQUENCY	COMMENTS (i.e. side-effects)

PAST MEDICATIONS (Psychiatric and Non-Psychiatric)

MEDICATION	DOSE / DURATION	RESPONSE & ADVERSE EFFECTS

ALLERGIES (please list)

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<p>Current alcohol/substance use: <input type="checkbox"/> None <input type="checkbox"/> Yes: please describe _____ _____ Current substance(s) used:</p>	<p>Past treatment for alcohol/substance use: <input type="checkbox"/> None <input type="checkbox"/> Yes: please specify _____ _____</p>
<p>Does this client have any medical illnesses? <input type="checkbox"/> None <input type="checkbox"/> Yes: please specify _____ _____</p>	<p>Is the client partially/fully disabled from working? <input type="checkbox"/> No <input type="checkbox"/> Yes: specify _____ _____</p>
<p>Is the client involved in current/pending civil/criminal litigation? <input type="checkbox"/> No <input type="checkbox"/> Yes: please specify _____ _____</p>	<p>Is the client involved in current/pending compensation/insurance claims? <input type="checkbox"/> No <input type="checkbox"/> Yes: specify _____ _____</p>
<p>Does the client have a history of aggression/violence? <input type="checkbox"/> No <input type="checkbox"/> Yes: specify _____ _____ _____</p>	<p>Does this client have a psychiatrist? <input type="checkbox"/> No <input type="checkbox"/> Yes: specify _____ _____ Name of psychiatrist: _____ Phone #: _____</p>



CONSENT TO DISCLOSURE AND COLLECTION OF PERSONAL HEALTH INFORMATION

I, _____
(Name of client or Substitute Decision Maker "SDM")

Of _____
(Address)

Authorize the disclosure and collection of personal health information between:

_____ and
(Name of person/agency disclosing information)

_____ Canadian Mental Health Association Toronto Branch
(Name of person / agency requesting information)

With regards to:

_____ (Name of client) _____ (Date of Birth)

_____ (Address)

All information obtained will be kept confidential between the parties specified above.

I understand that I may withdraw this authorization at any time in writing.

Name of client/SDM – please print

Name of witness – please print

Signature of client/SDM

Signature of witness

Date



CONSENT TO DISCLOSURE AND COLLECTION OF PERSONAL HEALTH INFORMATION

I, _____
(Name of client or Substitute Decision Maker "SDM")

Of _____
(Address)

Authorize the disclosure and collection of personal health information between:

_____ and
(Name of hospital / doctor disclosing information)

_____ Canadian Mental Health Association Toronto Branch
(Name of person / agency requesting information)

With regards to:

_____ (Name of client) _____ (Date of Birth)

_____ (Address)

All information obtained will be kept confidential between the parties specified above.

I understand that I may withdraw this authorization at any time in writing.

Name of client/SDM – please print

Name of witness – please print

Signature of client/SDM

Signature of witness

Date