710 Victoria Ave. E, Thunder Bay, ON, P7C 5P7
Phone: (807) 624-3400
Fax: (807) 624-3525

THE Access Point NORTHWEST

Application Form

Privacy Policy

Purpose for Collection and Use of Personal Health Information (PHI)

We collect, use, and disclose PHI only for the purposes of identifying the appropriate service needs as well as:

- Collecting relevant information contained in the records maintained by the organizations associated with The Access Point Northwest.
- Making referrals to the associated agencies for services, and to fulfill other purposes required or permitted by law.
- Sending this application to any agencies that will be providing services.
- Disclosing the PHI to a person or organization other than those associated without consent in limited circumstances required by law, such as emergencies of child welfare concerns.
- Use of de-identified PHI about applicants to plan and deliver services, for program evaluation, for statistical purposes, and for reporting to our funders.

Privacy Officer

If there are any questions or concerns about privacy, please contact our Privacy Officer with The Access Point Northwest at (807)-683-8200. If there are still concerns, please contact the Office of the Information and Privacy Commissioner at 1400-2 Bloor St E, Toronto, ON M4W 1A8, (416) 326-3333.

Referral Process

Please fill out all included pages. To withdraw the application, please contact (807) 624-3465.

☒ **Counselling and Group Services** **(Outpatient Mental Health)** (may be **completed only by a physician or nurse practitioner**, or with the authorization of a physician or nurse practitioner).

☐ I declare that the **primary care provider** ______________________ (Name of the PCP) is aware and in agreement with the referral.

Declaration and Consent

☐ I have done my best to ensure that all information provided on this application is correct.

☐ I have discussed this application with the applicant and obtained the applicant's knowledge and voluntary consent to make this referral.

☐ The applicant consents to the collection, use, and disclosure of the personal health information provided.

☐ The applicant understands that the personal health information provided on this application may be shared by relevant agencies included with The Access Point Northwest.

☐ The applicant consents to The Access Point Northwest to access medical records relevant to this application.

☐ The applicant consents that if the application is not accepted, it can be forwarded to a program outside The Access Point Northwest.

Name of Referrer: full name with credentials ______________________ Agency/Department: ______________________

Contact Number: ______________________ Fax Number: ______________________

Please attach any relevant consult letters, test results, or other pertinent medical records.

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Contact Information (paste label over top of this section)

First/Given Names(s): ____________ Last Name: ____________

Address: ____________

Phone Number: ____________ Can leave message? ☐ Yes ☐ No

Alternate Number: ____________ Can leave message? ☐ Yes ☐ No

Email: ____________ Preferred Language: ____________

Date of Birth: month / day / year Health Card #: ____________

Gender: ☐ Female ☐ Male ☐ Other Indigenous? ☐ Yes ☐ No

Indigenous Service Preferred? ☐ Yes ☐ No

Medical Contact

Does the applicant **have a primary care provider** (physician or nurse practitioner)? ☐ Yes ☐ No

Name: ____________ Agency/Clinic: ____________

Phone Number: ____________ Fax Number: ____________

Existing Supports

If the applicant is currently working with any **other service providers**, please list below:

Agency 1: ____________ Agency 2: ____________

Contact Name: ____________ Contact Name: ____________

Contact Number: ____________ Contact Number: ____________

Does the applicant have access to an **Employee Assistance Program**? ☐ Yes ☐ No

Has the applicant been referred for **other mental health programs**? ☐ Yes ☐ No

Reason for the Referral

*Please briefly describe the **reason(s) for the referral**, including any **clinical questions**, **diagnoses**, description of symptoms, requested services, support needs, etc.*

Primary Symptom: ____________ Secondary Symptom: ____________

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Mental Health Risk Factors

To what degree is the applicant's daily **function impaired** by these symptoms? ☐ Mild ☐ Moderate ☐ Severe

Does the applicant have a chronic **history of mental health** problems? ☐ Yes ☐ No

Is there a **formal diagnosis** of mental illness (if yes, please answer below)? ☐ Yes ☐ No

Primary diagnosis: Secondary diagnosis:

Has the applicant **recently experienced psychosis**? ☐ Yes ☐ No

First experience with psychosis? ☐ Yes ☐ No ☐ Not Sure

Is **excessive recreational drug, alcohol use, or gambling** a concern? ☐ Yes ☐ No

Is this referral for **addictions treatment**? ☐ Yes ☐ No

Is there **current involvement** with an addictions treatment program? ☐ Yes ☐ No

Is there involvement with a **methadone program**? ☐ Yes ☐ No

Has the applicant had **suicidal thoughts** in the past month? ☐ Yes ☐ No

Has a **plan** to suicide? ☐ Yes ☐ No

Has **attempted** to suicide in the past month? ☐ Yes ☐ No

Does the applicant have a history of **aggressive or destructive behaviour**? ☐ Yes ☐ No

Describe:

Has the applicant been to the hospital in the past year **due to mental health**? ☐ Yes ☐ No

Is the applicant currently in/or discharged in the past month from the **hospital inpatient mental health program** (Adult Mental Health)? ☐ Yes ☐ No

If female, is the applicant pregnant or has recently (24 mo.) given birth? ☐ Yes ☐ No

Is **peri-partum depression** a concern? ☐ Yes ☐ No

Is the applicant **currently homeless or at risk** of becoming homeless? ☐ Yes ☐ No

Are **family/relationship issues** affecting the applicant's mental health? ☐ Yes ☐ No

Are **socioeconomic issues** affecting the applicant's mental health? ☐ Yes ☐ No

Are **legal issues** affecting the applicant's mental health? ☐ Yes ☐ No

Is this applicant **transitioning from a youth mental health** program (check any that apply)?

☐ Child and Adolescent Psychiatry ☐ Children's Centre Thunder Bay ☐ Dilico

Other Illness/Disability

☐ **Concurrent Disorders** (substance dependence with mental illness.)

☐ **Dual Diagnosis** (developmental impairment with mental illness.)

Currently receive service(s) through DSO (Developmental Services)? ☐ Yes ☐ No

If no, has an application been submitted? ☐ Yes ☐ No

☐ **Neurological** (head/brain injury, epilepsy, cognitive disorders etc.)

Active medical condition: ☐ Auto-immune Condition ☐ Cancer ☐ Cardiac Disease ☐ COPD ☐ Diabetes ☐ HIV ☐ HEP ☐ HTN ☐ Stroke

☐ **Other chronic illness, physical disability, or sensory loss/deficit:** ______________________