

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.

The following referrals can only be completed by the primary care provider or someone willing to act as the most responsible provider (MRP):

_____ (Billing or College Number)

- Diagnostic Assessment or Medication Review or Dual Diagnosis.**

*Applicants whose primary care provider is in a **shared mental health care designated site** will receive psychiatric services on that site. Please contact (807) 624-3473 for further information.*

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.

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: _____

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: _____

Medication Review

Does the applicant require a **medication review**? Yes No

If the applicant is **currently taking ANY medications**, please indicate below, or attach a medication list.

Medication	Dosage\Frequency

Diagnostic Assessments

Does the applicant require a **diagnostic assessment** (check any that apply)?

Diagnostic Assessment: (Choose this option if you are seeking an opinion on whether the client meets criteria for a mental disorder)

What is the specific referral question?

What are your current diagnostic impressions?

Additional Information

Is this a psychiatry referral for an inpatient currently at St. Joseph's Hospital? Yes No

If the applicant has **had a diagnostic assessment/medication review done in past year**, please include the consult letter and summarize the reasons for re-assessment below:

Is this assessment **required for third party reasons** (i.e. Insurance, WSIB, Custody, or Licensing)? Yes No

If yes, please summarize the reasons for assessment: