Health PEI Santé Î.-P.-É.

REFERRAL FORM

Mental Health Structured Residential & Day Programming

Please send referrals by fax to 902-288-1203

SERVICE OVERVIEW

Structured Residential Program

- An intermediary level of care that falls between community and inpatient services, for clients who do not require an acute care stay but have mental health and living needs that cannot currently be supported at home.
- 28-day **residential** program (eight beds), which includes:
    - Attend Day Program (Monday-Friday)
    - Recreation activities
    - Pharmacy education
    - Life skills development (cooking, cleaning, etc.)
- This program is considered independent living, and thus, clients are responsible for their own laundry, cooking, and light cleaning.

Structured Day Program

- Intensive outpatient programming for clients whose mental health and living needs can be supported outside of residential services.
- 4-week day program (9am-3pm, Monday-Friday), which includes:
    - Life skills development (job readiness, budgeting, etc.)
    - Psychoeducation groups
    - Family support groups
    - Facilitating safe return to the community (linkages to community & governmental agencies)

REFERRAL PROCESS

Referrals can be made by a **Psychiatrist, Family Physician, Psychologist, Social Worker, Nurse, or Nurse Practitioner** and are sent directly from Inpatient Acute Care services, government agencies (e.g., Social Development, Justice), or from a community service provider.

Once received, referrals are assessed for eligibility and suitability. If all criteria are met, the client will be contacted for an intake assessment within 3-5 days of receiving the referral.

Please Note: The final disposition may be different than the original requested service. Clinical discretion and client intake may indicate that a client is better suited for one program (day program or residential), over the other. Clients will only be placed on the waitlist for the recommended service.

Structured Residential Program:

- Voluntary & willing to engage in treatment/programming
- Aged 18 or over
- Housing Secure
- Have a mental health condition that could benefit from this program, and are currently linked with a psychiatrist, family physician, or mental health clinician
- Psychiatrically stable – do not require acute care in an inpatient setting
- Require extensive skill development in the areas of independent living
- Are capable and comfortable participating in group activities (e.g., group therapy, group recreation, etc.)
- Are capable and comfortable living in a congregate living settings (i.e., shared kitchen, bathroom, living room, etc.)
- Agree to assist with residential tasks such as cleaning, cooking, laundry, etc.
- Compliant with medications (or amenable to support with medication management/compliance)
- Can commit to being substance-free for duration of stay
- Can commit to consistent attendance during day program hours (Monday-Friday, 9am-3pm)

Structured Day Programming:

- Voluntary & willing to engage in treatment/programming
- Aged 18 or over
- Have a mental health condition that could benefit from this program, and are currently linked with a psychiatrist, family physician, or mental health clinician
- Psychiatrically stable – do not require acute care in an inpatient setting
- Are capable and comfortable participating in group activities (e.g., group therapy, group recreation, etc.)
- Able to independently administer medications
- Can commit to being substance-free during scheduled day programming
- Can commit to consistent attendance during day program hours (Monday-Friday, 9am-3pm)

For more information, or clarification on the referral process, please call Structured Programming reception at (902) 288-1198

Health PEI Santé Î.-P.-É.

STRUCTURED RESIDENTIAL AND DAY PROGRAM REFERRAL FORM

Requested Service: ☐ Residential Program ☐ Day Program

Date of Referral (dd/mm/yyyy): _____

Please Note: Please type information into this form if possible. Documents can be attached to further support the information provided.

REFERRAL SOURCE INFORMATION

Contact Name: _____ Telephone: _____

Referring Unit/Agency/Provider Type: _____

Have you provided treatment to this client in the past? ☐ Yes ☐ No

CLIENT INFORMATION

Name: _____ Date of Birth (dd/mm/yyyy): _____ Age: ____

PHN#: _____ Expiry: _____

Client's Address: _____

Cell Phone Number: _____ Can an identifying message be left? ☐Yes ☐ No

Alternative Phone Number: _____ Can an identifying message be left? ☐Yes ☐ No

Client's Email Address: _____

Emergency Contact Name: _____ Phone Number: _____

Client's Gender Identity: ☐Cis-female ☐Cis-male ☐Trans female ☐Trans male ☐Two-spirit ☐Genderqueer ☐Agender ☐Non-Binary ☐Prefer not to disclose ☐Not listed: _____

Client's Pronouns: _____

Current living situation: ☐ Independent ☐ With roommates ☐ With parents ☐ Shelter ☐ No fixed address ☐Community Care Facility ☐ Other: _____

Employment Status: ☐Full-time ☐Part-time ☐Unemployed ☐Homemaker ☐Student ☐ Seasonal ☐Retired ☐Other: _____

Is the client pregnant? ☐Yes ☐ No ☐ Unknown Does the client have children? ☐Yes ☐ No

GUARDIAN INFORMATION (Please complete if client is under the care of a Public or Legal Guardian)

Guardian Name(s): _____

Relationship to client: _____

Primary Phone Number: _____ Alternative Phone Number(s): _____

Health PEI Santé Î.-P.-É.

CONNECTIONS WITH MENTAL HEALTH SERVICES

Please list physicians, therapists, services, agencies, or organizations that the client is currently involved with as part of their Mental Health treatment (i.e., psychiatrist, private therapist, Community Mental Health and Addictions, Addictions Counsellors, Peer Support Groups, etc.):

LEGAL HISTORY

Please check all that apply:

☐ Client is under CCRB conditions
☐ Client is on probation
☐ Client is on parole
☐ Client is ankle-monitored
☐ There are emergency protection, no-contact, and/or restraining orders involving this client

Probation or Parole Officer: _____ Phone Number: _____

Please list any pending court dates: _____

POTENTIAL BARRIERS

Please identify any potential barriers that may prevent the client from fully participating in Structured Housing and/or Day Programming:

☐No barriers ☐ Literacy Level ☐ Housing (maintaining own apartment) ☐ Work
☐Mobility ☐ Language ☐ Medical Condition ☐ Behavioural ☐Other:

If there are identified barriers, please provide detail:

IDENTIFIED NEEDS

For Structured Residential Program AND Day Program referrals, please describe client's life skills development needs (i.e., what skills are the client hoping to gain from this service)

If referring to Structured Residential Program, please describe why the client would benefit from residential programming (i.e., what are their residential support needs?)

Please provide a personal statement from the client explaining why they would like to enter Structured Residential or Day Program:

☐ I have attached additional supporting documents with this referral: (Please list documents)

In signing below, I acknowledge that the client is aware that I am making this referral on their behalf. I have explained the program descriptors, eligibility criteria, and referral process to the client. All information provided in this referral is true and accurate to the best of my knowledge.

Referring Source Name (please print): _____

Referring Source Signature: _____

Date: _____

In signing below, I authorize this referring clinician to disclose my personal information, including all relevant medical information, as part of my referral for Structured Residential/Day Program Services. I also confirm that I have provided the referral source with true and accurate information.

Client Name (please print): _____

Client Signature: _____

Date: _____