Please Provide Document to Client AND Review

Collaborative Care Clinic: Program Information Sheet

What is the Collaborative Care Clinic?

CCC is a mental health service that offers comprehensive psychiatric assessments, medication consultations and short-term mental health treatment for adults over 18 years of age. The CCC team is comprised of an interdisciplinary team that includes a psychiatrist, a mental health clinician, and a case manager.

CCC's core services include:

- Psychiatric assessment and diagnosis
- Psychiatric treatment recommendations
- Mental health treatment recommendations

Based on need and availability, CCC may also be able to offer:

- Group therapy
- Short-term case management

How long does CCC see clients?

CCC operates under an 'episode of care' model. This means that we will see the client until their mental health is stabilized. Their care will then be transferred back to their primary care provider with a detailed report and treatment recommendations. The client can be referred again if they need further care and every effort will be made for them to see the same team members.

The primary care provider has the overall responsibility for directing and coordinating the referred client's care and management of their mental health. We require that the client's primary care provider remain active in their client's care during their treatment within our clinic.

Do you see everyone that is referred?

All referrals are assessed to determine suitability to ensure clients are matched with the appropriate team as not all clients require a psychiatric assessment.

The following will cause a delay in your referral being processed:

- Specific reason for referral is unclear or vague
- Referral is illegible
- Insufficient information or referral form is incomplete

CCC has the following exclusion criteria:

- Client resides out of our catchment area (see the top of the referral form)
- Requests to follow client on a long term basis
- Client currently has a psychiatrist
- Consultations for autism/intellectual disability/pervasive developmental disorder
- Consultations for medical marijuana
- Requests for 3rd party assessments (i.e. Children's Aid Society, court, insurance, Ministry of Transportation)
- Consultations for medical assistance in dying
- Clients requiring trauma therapy for complex trauma

Please note that forms that are incomplete or not clearly printed will be returned.

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Electronic Communications: Client Information Sheet

Unity Health Toronto (St. Michael's Hospital, St. Joseph's Health Centre, and Providence Healthcare) would like to communicate with you by email or text. You may also want us to email or text a loved one or a person involved in supporting your care. We need your permission to do so.

Basic Information - General health information and hospital announcements only

Only your health condition and appointment information will be sent. This may include:

- Information about your appointments:
  - The time and date of your appointment,
  - The name of your care provider or clinic, and
  - The location of the clinic or office (for in-person visits), the phone number to call (for phone visits), or the link to use (for video visits), and
  - The wait time for your appointment
- Links to sign up for patient portals
- Links to surveys about your experience at the hospital
- Questions for research about your experience at the hospital
- General information about your disease or condition (such as newsletters from the clinic or educational materials)
- General hospital announcements and clinic announcements
- General changes to clinic policies

If you have questions…

If you have any questions, or if you change your mind, please contact your doctor, care team, or Patient Registration as soon as possible. For questions or concerns about your privacy, please visit our website at https://unityhealth.to/protecting-your-privacy/

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FREQUENTLY ASKED QUESTIONS

What do I need to know about emails and texts?

Emails and text messages are not protected in the same way that phone calls and letter mail are protected. This means that if someone sees the texts or emails, they may know that you are a patient at Unity Health Toronto. They may also see any other information shared in the email or text message.

- Emails and texts may be read or saved by your internet or phone provider (such as Rogers).
- There is always a chance that an email could be read by others, or changed without you knowing.
- Emails can contain a virus that can harm your computer.
- If your phone is lost or stolen, text messages could be read by others.

Is email and text communication optional?

Yes. Email and text communication are not required. If you decide that you do not want to communicate in this way, the hospital will continue contacting you by telephone or regular mail. If you chose not to email or text, your care will not be affected.

Can I change my mind about email and text?

Yes. You can change your mind about email and text communication at any time by contacting your doctor or care team.

How does Unity Health Toronto protect my information?

- Your phone number and email address are kept secure in our systems.
- Any information that you send us may be added to your record if it is important for your care.
- Your email may be shared with other hospital staff if it is needed for your care, to run the Hospital, or for another reason that the law allows.

Can I use text or emails for an emergency?

No, emails sent to the hospital may not be read right away. **Do not send text messages or email for medical emergencies**. If you need immediate help, call your clinic or health care provider, or go to the Emergency department.

What else do I need to do?

Check your emails and text messages regularly. Tell the hospital if you or your loved one changes phone numbers or email addresses.

IMPORTANT: Unity Health Toronto will never ask patients or families to send personal identifiers by text message or email (OHIP number, hospital number, or address). If you get a text message or email asking for this information, please do not respond. This may be a harmful message.

Referral Form for Collaborative Care Clinic

Location: St. Joseph's Health Centre, 30 Queensway, 5th Floor Gilgan Toronto, ON

Phone Number: 416-530-6717 **Fax to Intake at**: 416-530-6774

INFORMATION FOR REFERRING PRACTITIONER:

- **A physician or nurse practitioner referral is required** (self-referral is not accepted)
- It is preferred that the referral comes from the treating physician
- The referring physician **must provide concurrent care during the time-limited treatment offered within the outpatient mental health program.**
- **Referral** to the Collaborative Care Clinic **does not guarantee** the client will be seen by a psychiatrist

INFORMATION FOR THE CLIENT BEING REFERRED:

- Please ensure that your **client consents to the referral** being made
- Please ensure that your client is aware that **services are time-limited**
- Our intake team will make **two attempts to contact the client** and leave two voicemails, when consent is provided. If the client cannot be reached, the referring provider will be notified.
- Given St. Joseph's Health Centre is a teaching hospital, your client can expect to have residents or other learners involved in their care.
- Given St. Joseph's Health Centre is an academic research hospital, your client may be invited to participate in research opportunities. They do not need to accept.
- If eligible, some treatments will require an escort to accompany the client home after treatment sessions. Please note that the client will have to arrange this.

PLEASE NOTE THE FOLLOWING CRITERIA:

Referral will be accepted if the following criteria are met:

☐ Referring practitioner agrees to provide concurrent care during the time limited course of care at Collaborative Care Clinic. **No additional psychiatric follow-up will be provided once treatment is completed.**

☐ Client accepts that treatment and services are time-limited

☐ Client does not require consultation for:

- Autism/intellectual disability/ Pervasive Development Disorder
- Consultation for medical marijuana
- Medical assistance in dying
- Third Party Assessments (i.e. Court, Insurance, Ministry of Transportation)

☐ Client's primary presentation is not substance use related

☐ Client lives within the **catchment area**

☐ Client is 18 years of age or older

M6E, M6H, M6K, M6M, M6N, M6P, M6R, M6S, M6S, M8V, M8X, M8Y, M8Z, M9A

Please note that forms that are incomplete or not clearly printed will be returned.

REFERRING PRACTITIONER INFORMATION:

NAME:	BILLING #:
ADDRESS:	TELEPHONE:
POSTAL CODE:	FAX #:
ORGANIZATION/CLINIC:	E-MAIL ADDRESS:

Does your client currently have a psychiatrist? ☐ Yes ☐ No

CLIENT'S CONTACT INFORMATION:

Consented to referral **and** has been provided with 'CCC-Program Information Sheet'?

LEGAL FULL NAME:_____ CHOSEN NAME & PRONOUN: _____

DATE OF BIRTH:_____ GENDER:

ADDRESS:_____ ☐ ***NO FIXED ADDRESS***

POSTAL CODE: _____

HEALTH CARD NUMBER:_____ VERSION CODE: _____

TELEPHONE NUMBER:_____ ALTERNATIVE PHONE NUMBER: _____

CONSENT TO ELECTRONIC COMMUNICATION: ☐ YES ☐ NO

E-MAIL ADDRESS: _____

SOURCE OF INCOME (I.E. ONTARIO WORKS, EI ETC.): _____

PREFERRED LANGUAGE? ☐ English ☐ Other:_____ ☐ Interpreter Required

SPECIAL NEEDS OR ADDITIONAL SUPPORTS REQUIREMENTS: ☐ YES ☐ No ☐ N/A

If yes, please provide further information:

SECONDARY CONTACT: FULL NAME:_____ RELATIONSHIP: _____

☐ NEXT OF KIN (NOK) ☐ SUBSTITUTE DECISION MAKER (SDM)

☐ POWER OF ATTORNEY (POA) ☐ LEGAL GUARDIAN

☐ OTHER:_____

SECONDARY CONTACT IS AWARE OF REFERRAL:

CONSENT TO SPEAK WITH SECONDARY CONTACT:

Please note that forms that are incomplete or not clearly printed will be returned.

PRESENTING CONCERNS/ REFERRAL GOALS:

REASON(S) FOR REFERRAL:

☐ Connect with time-limited Mental Health Services
☐ Clarify Diagnosis ☐ Medication Review/Consult
☐ Other: _____
☐ Prenatal Mental Health Services:
Due Date: _____
Or Number of Month(s) Postpartum: _____

Please describe primary reason for referral, current symptoms, and provide details of previous treatments:

Please complete the screening tool with the client below:

PHQ-9 Score: 0 GAD-7 Score: 0

CURRENT MEDICATION (List ALL Medications including Dose and Frequency):

☐ *No prescribed medications*

MEDICATION	DOSE	START DATE	OUTCOME

ALLERGIES: ☐ *No Known Allergies*

Past Psychiatric History (please include most recent consultation, discharge summary or note):

Has the client been hospitalized in the last six months? ☐ Yes ☐ No ☐ Unknown

PAST MEDICATION TRIALS (Alternatively, you may attach a list of previous medications):

MEDICATION	DOSE	DATE	OUTCOME

☐ *No previous medication trials*

AGENCIES, MENTAL HEALTH THERAPIES OR SERVICES FROM THE LAST TWO YEARS:

PAST PSYCHOTHERAPY TRIALS:

Please select all relevant trials and include details (date, duration, and outcome)

☐	Cognitive Behavioral Therapy	☐	Mindfulness Based Therapy
☐	Dialectical Behavioral Therapy	☐	Cognitive Processing Therapy
☐	Interpersonal Therapy	☐	Psychodynamic Therapy
☐	Other		

MEDICAL HISTORY (Please include relevant reports):

SUBSTANCE USE (Please include current substances, amount, frequency of use, etc.):

Is there any active substance use in the last 90 days? ☐ Yes ☐ No

If yes, Please describe:

Is there a history of substance use disorder? ☐ Yes ☐ No

If yes, Please describe:

RISK & SAFETY CONCERNS:

This information is used to optimally plan for the client's first appointment and to ensure their safety and their safety of our staff.

RISK ISSUES	PRESENT		PAST		DETAILS
	YES	NO	YES	NO	
Criminal Charges	☐	☐	☐	☐	
Violent Behavior	☐	☐	☐	☐	
Suicide Attempt(s)	☐	☐	☐	☐	
Self-Harm Behavior	☐	☐	☐	☐	

ADDITIONAL COMMENTS:

Client Consents and Referral Source Acknowledgements:

Initials Here Client is aware they are required to be within the province of Ontario while receiving care at the Collaborative Care Clinic

I, the Referring Practitioner Acknowledge,

Initials Here That I will be the Most Responsible Practitioner or 'MRP'. The MRP has the overall responsibility for directing and coordinating the referred client's care and management of their mental health. I have discussed with my client other aspects of their care. If I discharge the client from my practice (i.e. no longer providing care to the client referred) before or during their episode of care in the Collaborative Care Clinic I will connect the client to a different primary care provider who will take over their care upon discharge from Collaborative Care Clinic.

Initials Here That I have provided the most recent and accurate information required for this referral.

Initials Here Outpatient Mental Health Program does not provide urgent consultations and does not respond to questions or concerns outside of listed hours of operation.

Initials Here I have read the conditions of referring to the Collaborative Care Clinic and will collaborate with the clinic during treatment, and continue care of my client upon discharge from the program.

Signature:

CPSO # (*if applicable*):

_____

Name and Designation (print):

_____

Date of Referral:

_____

Print to Fax: **Print Form** Clear Form: **Clear Form**

Please note that forms that are incomplete or not clearly printed will be returned.

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	☐ 0	☐ 1	☐ 2	☐ 3
2. Feeling down, depressed, or hopeless.	☐ 0	☐ 1	☐ 2	☐ 3
3. Trouble falling or staying asleep, or sleeping too much.	☐ 0	☐ 1	☐ 2	☐ 3
4. Feeling tired or having little energy.	☐ 0	☐ 1	☐ 2	☐ 3
5. Poor appetite or overeating.	☐ 0	☐ 1	☐ 2	☐ 3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	☐ 0	☐ 1	☐ 2	☐ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	☐ 0	☐ 1	☐ 2	☐ 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	☐ 0	☐ 1	☐ 2	☐ 3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

☐ **Not difficult at all** ☐ **Somewhat difficult** ☐ **Very Difficult** ☐ **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	☐ 0	☐ 1	☐ 2	☐ 3
2. Not being able to stop or control worrying.	☐ 0	☐ 1	☐ 2	☐ 3
3. Worrying too much about different things.	☐ 0	☐ 1	☐ 2	☐ 3
4. Trouble relaxing.	☐ 0	☐ 1	☐ 2	☐ 3
5. Being so restless that it's hard to sit still.	☐ 0	☐ 1	☐ 2	☐ 3
6. Becoming easily annoyed or irritable.	☐ 0	☐ 1	☐ 2	☐ 3
7. Feeling afraid as if something awful might happen.	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

☐ **Not difficult at all** ☐ **Somewhat difficult** ☐ **Very Difficult** ☐ **Extremely Difficult**

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