Community Living Psychiatry Service
(CLPS) Consultation Referral Form

Eligibility Criteria

In order to be eligible for CLPS, the individual must be open to pparitcipate in the Community Living disABILITY Services (CLDS) program and meet the criteria of an adult living with an intellectual disability according to "The Adults Living With an Intellectual Disability Act" or the Provincial Alternative Support Services (PASS) program.

Referral Process (to be initiated by the Community Service Worker (CSW))

1. Complete the form (please print clearly) and fax to 204- 940-1992. This consent must be signed by the client or Substitute Decision Maker (SDM) before the referral will be considered.
2. Additional documentation in regard to program admission criteria may be requested. Relevant reports and assessment documents must be faxed to CLPS Intake at 204 -940-1992.
3. Completion of this form does not guarantee service.

Client Information:

Full Legal Name: _____ Preferred Name: _____

Gender: _____ ☐ Prefer not to disclose DOB: _____

Current Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ Cellular: _____ Provincial Health ID Number (PHIN) *(9 digits)*: _____

Family Physician: _____ Last Physical Exam: _____

School/Day Program _____ Phone: _____

SDM or Next of Kin Information (if applicable):

Legal Guardian Name: _____

Current Address: _____ Relationship: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ Cellular: _____

Agency Contact Information:

Agency Name: _____

Address: _____ City: _____

Province: _____ Postal Code: _____ Telephone: _____ Cellular: _____

Community Service Worker (CSW) Contact Information:

CSW Name: _____

Address: _____ City: _____

Province: _____ Postal Code: _____ Telephone: _____ Cellular: _____

Other Involved Professionals:

☐ Occupational Therapist
☐ Psychiatrist
☐ Psychologist / BPS
☐ Counsellor
☐ Are there any other Professionals Involved? If yes, please specify:

Language Interpreter Required? ☐ Yes ☐ No

Consent for Information and Treatment

Full Legal Name: _____

Date of Birth (DOB): _____

Manitoba Health Card *(6 digits):* _____ Personal Health Identification Number (PHIN) *(9 digits):* _____

I, _____ , (name) hereby authorize Community Living Psychiatry Service to receive or exchange verbal and/or written information regarding above named with the following persons/agencies.

1. _____
2. _____
3. _____

IInformation shared for the purpose of Community Living Psychiatry Service assessment, treatment, diagnosis, and eligibility of services.

DATED this _____ (day/date) of _____ , 20 _____

Signature of Client or Substitute Decision Maker

_____

Witness Signature

_____

Consent for Psychiatric Assessment/Treatment

I, _____ DOB: _____

Provide permission for Community Living Psychiatry Service, of the Department of Families, Community Service Delivery, to provide the following services:

Intake assessment with Nurse Clinician to:

1. Collect information about the individual and nature of concerns.
2. Provide information and Community Living Psychiatry Service.
3. Provide basic recommendation/education.

Psychiatric Consultation Services:

1. Meeting with psychiatrist/nurse clinician for the purpose of assessment and treatment recommendations.

Nurse Clinician Support / Education Services:

1. To provide individual support and monitor treatment recommendations.
2. Work closely with individual's support network (Psychiatrist, CSW, Family, Agencies, and Hospital) to support treatment interventions.
3. Initiate medical interventions to support treatment (injections/blood work).

Participating in Community Living Psychiatry Service is voluntary. All information will be kept private unless the individual or Substitute Decision Maker provides verbal or written permission to share this information. For safety purposes, Community Living Psychiatry Service is legally required to report confidential information if they have knowledge of or believe that an adult living with an intellectual disability is being abused, neglected or a witness to abuse.

DATED this _____ (day/date) of _____ , 20 _____

Signature of Client or Substitute Decision Maker

_____

Witness Signature

_____

Intake Referral Form

This Section to be completed by Physician/Nurse Practitioner

Referring Physician:

Referring Physician: _____ Billing Number: _____

Address: _____ City: _____

Province: _____ Postal Code: _____ Telephone: _____ Fax: _____

Medical Diagnosis/Relevant Medical History/Social History & Current Medications (include Dosage):

What are the presenting concerns? *(Please check all that apply)*

☐ Self-Harm	☐ Anxiety	☐ Obsessions / Compulsions
☐ Suicidal Ideation	☐ Behaviour / Dysregulation	☐ Sleep Problems
☐ Suicide Attempts	☐ Depression / Mood	☐ Substance Abuse
☐ Aggression	☐ Hallucinations / Delusions	☐ Past History of Trauma
☐ Anger / Oppositional Behaviour	☐ Inattention	☐ Other: ____

Please provide details on severity of the psychiatric concern and the effect on the client's functioning:
(please attach copies of relevant reports)

DATED this _____ **(date) of** _____ **, 20** _____

Signature of Prescribing Physician / Nurse Practitioner: _____

Please indicate who will be following up with this client after consultation visit is completed:

1. Prescribing Physician / Nurse Practitioner: _____
2. Community Service Worker: _____