Community Homes for Opportunity Program
Resilience Huron Perth Mental Health Services
Resident Referral and Assessment Form

Name ____S.I.N. # _________________
Current Place of Residence: ____
Date of Birth ___________ Place of Birth _________________________Certificate ☐
Marital Status _______Sex_______________
Languages Other Than English __________________ Religion __________________

Source of Income ___________________________ ODSP # (If Applicable) _______________
Substitute Decision Treatment ☐ Finance ☐ Name: ________________________________
Public Trustee File #________________________________

Health Card #: ________________________ Card Expiry Date _______________

Next of Kin: ____ Relationship ______________
Address: ____ Telephone ________________
Family: ____
____
Name of Referring Source: _______________________ Telephone ________________

Physical Health

Health Problems: (Ex. Epilepsy, Diabetes, Heart Disease, Stroke, Surgery, Infections, Etc.)
Yes ☐ No ☐
____
____

Physical Handicaps: (Ex. Deformities, Amputations, Prosthesis, Mobility Issues)
Yes ☐ No ☐
____
____

Allergies: Yes ☐ No ☐

Medication: ____
Food: ____

Mental Health

Orientation:	Intact	Impaired
Time	☐	☐
Place	☐	☐
Person	☐	☐

Memory:	Intact	Impaired
Immediate	☐	☐
Recent	☐	☐
Remote	☐	☐
Hallucinations:	☐ Yes	☐ No

What are these like? How often do they occur? How do you deal with these?

Concentration: ☐ Good ☐ Fair ☐ Poor

	No	Yes	If Yes Describe
Obsessions & Compulsions	☐	☐	
Phobias	☐	☐	
Hypochondriacal Symptoms	☐	☐	
Past Suicide Attempts	☐	☐	
Verbalized thoughts of Suicide	☐	☐	
Self-Harm – Past Attempts	☐	☐	
Verbalizes thoughts of Self -Harm	☐	☐	
History of Aggression	☐	☐	
Verbalizes thoughts of Aggression	☐	☐	
History of Sexual Harm to Others	☐	☐	
Verbalizes thoughts of Sexual Harm to Others	☐	☐	
History of Fire Setting	☐	☐	
Delusions	☐	☐	
Depression	☐	☐	
Difficulties with the Law	☐	☐	
History of non-compliance with medication	☐	☐	
Substance abuse issues	☐	☐	

Please indicate signs that person may be becoming ill.

____

____

Please indicate any techniques in dealing with person that may be helpful.

____

____

Activities of Daily Living

Activity:	Dependent	Independent	Supervision	Assistance
Oral Hygiene/General Daily Grooming				
Bathing				
Dressing Self				
Toileting				
Feeding				
Laundry				

Incontinence Yes ☐ No ☐
Sleep Difficulties Yes ☐ No ☐

To Be Accompanied when in Community: Yes ☐ No ☐
Specify level of supervision and reason:

____

____

Attach additional information: **1) Copy of Care Plan** **2) Current Medications** **3) Social History**

I have explained the Community Homes for Opportunity Program to the applicant and I feel that he/she is an appropriate candidate. It is understood that should the applicant be accepted into the CHO Program, I will be expected to continue to be involved in a consultative role.

Signature: ___________________________________ Date: ________________
year/month/day

I have discussed the Community Homes for Opportunity Program with my worker and my physician. I understand and agree to abide by the rules and regulations of the program.

Signature: ___________________________________ Date: ________________
year/month/day

To be completed by CHO Program Staff

The applicant was accepted ☐ Yes ☐ No

If not accepted, specify reasons why Date: ___________________
year/month/day

If accepted, address of Home: Client # __________

Name of Worker Date of Placement

Date of Discharge from CHO Program: _________________
year/month/day

Discharge Address of Client: ____
____
____
____

Additional Information: ____
____
____
____
____
____
____
____

CHO Referral Form
Physician to Complete This Page

Medical Report & Discharge Summary

Name of Patient ____

A. Axis I ____

B. Axis II ____

C. Axis III ____

D Axis VI ____

Systemic Conditions: (Indicate applicable item and specify below)

Seizures ☐ Dysphagia ☐ Dysarthria ☐ Aphasia ☐ Dysuria ☐ Hemorrhoids ☐
Polyuria ☐ Diabetes ☐ Dyspnea ☐ Hernia ☐ Cardiac Failure ☐ Emphysema ☐
Arthritis ☐ Neurological Deficit ☐

Remarks:

____

____

Family Physician: ______________________________
Date of last physical examination: ____________________

Psychiatrist: ______________________________
Date of last psychiatric appointment: ________________

Optometrist: ______________________________
Last Examination Date: ___________________________

Dentist: ______________________________
Last Examination Date: ___________________________

Please attach current list of medications (Mar sheet)

Signature of Staff Physician: ________________________
Date: ________________________

Print Staff Physician Name: ________________________
Phone: ______________________

Please Include/ attach any pertinent information or documents.