

Healing Opportunities Promoting Empowerment (H.O.P.E.) TEAM Multidisciplinary Referral

(Addressograph)

Referral date: _____	Name of Patient: _____
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Casebook #: _____ Program: _____ Ward: _____

Primary Nurse/ Worker: _____ **ext:** _____

Social Worker: _____ **ext:** _____

Referent: _____	ext: _____
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Precautions, Restrictions and Considerations:
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- | | | |
|---|---|--|
| <input type="checkbox"/> Elopement Risk | <input type="checkbox"/> Suicidal Risk | <input type="checkbox"/> Hallucinations or Delusions |
| <input type="checkbox"/> Sexually Inappropriate | <input type="checkbox"/> Incontinent | <input type="checkbox"/> Perceptual Deficits |
| <input type="checkbox"/> Self-Abusive | <input type="checkbox"/> Pulmonary Disease | <input type="checkbox"/> Cognitive Deficits |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Epileptic | <input type="checkbox"/> Hearing Deficit |
| <input type="checkbox"/> Physical Disability | <input type="checkbox"/> Diabetic | <input type="checkbox"/> Visual Deficit |
| <input type="checkbox"/> Non-ambulatory | | |
| <input type="checkbox"/> Verbally Aggressive | <input type="checkbox"/> Physically Aggressive e.g. _____ | |
| <input type="checkbox"/> Allergies: _____ | | |
| <input type="checkbox"/> Comments: _____ | | |

Primary Diagnosis: _____

VOCATIONAL SERVICES	for information contact J. Kimball @ ext. 2280
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- Reason for referral:**
- | | | |
|--|--|---|
| <input type="checkbox"/> E.I./C.P.P. | <input type="checkbox"/> Prior to Hire Group | <input type="checkbox"/> Job Preparation Program |
| <input type="checkbox"/> Hospital Services Program | | <input type="checkbox"/> Rehabilitation Resources |
- NEMHC Academic Program:**
- | | | |
|--|---|--------------------------------|
| <input type="checkbox"/> Literacy | <input type="checkbox"/> Life Management Skills | <input type="checkbox"/> Co-op |
| <input type="checkbox"/> High School Credits | <input type="checkbox"/> Community Education (post-secondary) | |

OCCUPATIONAL THERAPY	for information contact C. Lewicki @ ext. 2287
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- Reason for referral:**
- Self Management Skills (time management, coping, interpersonal/social skills, goal development)
 - Prevocational Assessment (Work Interest Assessment, Learning Style Inventory, Work Skills Assessment)
 - Link to Community Resources (Specify): _____
- Groups:** Community Living (community living skills development)
- Gab 'N' Games (social and interpersonal skills development)
 - Job Skills (work skills development)
 - Lasting Impression Group (self-care skills development)
 - S.T.E.P. Program (basic skills development)

NATIVE SERVICES for information contact B. Butler @ ext. 2284/ L. Pizzale @ ext. 2282

Reason for referral:

- | | |
|---|--|
| <input type="checkbox"/> Regular Visits | <input type="checkbox"/> Groups |
| <input type="checkbox"/> Counselling | <input type="checkbox"/> Assessment |
| <input type="checkbox"/> Translation | <input type="checkbox"/> Social-Cultural Activities |
| <input type="checkbox"/> Community Visits (North Bay) | <input type="checkbox"/> Community Assessment |
| | <input type="checkbox"/> Home Visits/ Patient Escort |

LASTING IMPRESSION SALON for information contact B. Cameron @ ext. 2278

*note this service is for both male and female clients

CHAPLAINCY SERVICES for information contact J. Archambeault @ ext. 7878

*note if immediate Chaplaincy Services are required please contact J. Archambeault by telephone.

RECREATION for information contact C. Sevigny @ ext. 2269 / N. Newton @ ext. 2341

Please check the area of activity (s) being referred to:

- Craft Club
- Walking Club (Doctor's Signature required *) Signature _____ date: _____
- Fitness Room (Doctor's Signature required *) Signature _____ date: _____
- Hospital Wide Dew Drop Inn *
- Seniors Dew Drop Inn *

* Note if a patient being referred to the Dew Drop Inn is authorized to receive alcoholic beverages, please ensure that the physician signs the Pub Order.

***Pub Order (Dew Drop Inn Only)**

Physician's Signature: _____ Date: _____

Frequency of Pub Order:

- Each Visit Monthly Other (Specify) _____

For H.O.P.E. Team Members' use only:

Date Referral Received: _____

Lead Responsibility: _____

Date of Initial Contact: _____

Comments:

- Contact will be established within 5 working days of receiving this H.O.P.E. TEAM Referral.