RISE (Re-Engaging In Secondary Education) Referral Form

Please include CAMH consent forms for release of information - ***fax to 416-260-4197 or email to heather.roberts@camh.ca***

To be completed by referring clinician – Disclaimer * Students will not receive psychiatry or case management through the RISE PROGRAM & both are required for enrollment

Date: ____________________ **Referred by:** ____

Phone: ___________________________ **Email:** ____

STUDENT NAME: (surname) ______________________________ **(given name)** ____________________________________

DATE OF BIRTH: M/D/Y ____

PHONE (HOME) ____ **(CELL)** ____

STUDENT EMAIL: ____

ADDRESS: _________________________________ **City:** ______________________ **Postal Code:** _____________________

GENDER IDENTITY: M □ F □ Non-Binary□ Trans M->F□ Trans F->M □ 2S+□ Pronouns: ____________ **Prefer not to say□**

MAIN LANGUAGE SPOKEN: _______________ **INTERPRETER REQUIRED? (Y or N) Health Card #:** ________________________

LAST SECONDARY SCHOOL ATTENDED _______________________ **LOCATION:** ________________________________

LAST GRADE ATTENDED: _____________ **COMPLETED: (Y OR N) MONTH/ YEAR OF LEAVING:** _________________

***Please include a copy of your credit counselling summary & Individual Education Plan**

PARENT/GUARDIAN NAME: ____

PHONE: __________________________ **CELL:** _____________________ **EMAIL:** ___________________________________

COMMUNITY TREATMENT TEAM

CURRENT TREATING PSYCHIATRIST ____________________________________ **Billing #** _________________________

PHONE: __________________ **EMAIL:** ____________________ **ADDRESS:** _______________________________________

FREQUENCY OF CONTACT _________________________ **WILL THE STUDENT HAVE PSYCHIATRIC FOLLOW-UP FOR THE DURATION OF ENROLLMENT AT RISE?**

____

CURRENT COMMUNITY CASE MANAGER: ____

AGENCY: ____

PHONE (OFFICE) _______________________ **Cell:** ________________________ **EMAIL:** _____________________________

FREQUENCY OF CONTACT _________________________ **WILL THE STUDENT HAVE A CASE MANAGER OR THERAPIST FOR THE DURATION OF ENROLLMENT AT RISE?** ____

IMPORTANT * WHO WILL THE STUDENT GO TO FOR MANAGEMENT OF THEIR MENTAL HEALTH ISSUES WHILE AT RISE? I.e. IF IN CRISIS, NEED A MEDICATION CHANGE, or NEED RE-ASSESSMENT, MONITORING SCHOOL ATTENDANCE, IN NEED OF RESOURCES INCLUDING REGULAR COMMUNICATION WITH THE RISE TEAM?

____

____

PLEASE LIST ANY OTHER AGENCIES/PROVIDERS INVOLVED WITH THE STUDENT?
____

PSYCHIATRIC HISTORY

PRIMARY PSYCHIATRIC DIAGNOSIS (please specify): ____

____

HISTORY OF MENTAL HEALTH CONCERNS/SYMPTOMS (please specify):

____

____

HAVE YOU EVER BEEN ADMITTED TO THE HOSPITAL FOR MENTAL HEALTH/PSYCHIATRIC CONCERNS?

Yes No Unsure ____________ HOW MANY HOSPITALIZATIONS? _________________________

PLEASE LIST THE TWO MOST RECENT HOSPITALIZATIONS FOR MENTAL HEALTH/PSYCHIATRIC CONCERNS:

Date	Length of Stay (approx.)	Institution/Hospital	Reason for Admission

CURRENT MEDICATION:

Name	Dosage & Frequency	Poor	Variable	Good

RISK:

Risks		If yes, when?	Please provide some details
Suicide attempt/ideation	□ Yes □ No □ Not sure		
Deliberate self-harm	□ Yes □ No □ Not sure		
Aggressive behaviour	□ Yes □ No □ Not sure		
Legal involvement	□ Yes □ No □ Not sure		
Substance use	□ Yes □ No □ Not sure		

STUDENT HISTORY

Students' academic & wellness goals: ____

What educational difficulties does the student identify? ____

History of school attendance: ex: no issues; frequent absences, etc.: ____

Please provide any additional comments that are relevant to the student's school performance/experience?

____

____

Additional information:

Does the student need constant 1 to 1 support?	□ Yes □ No □ Not sure
Does the student function according to their chronological age	□ Yes □ No □ Not sure
Is the student able to independently:	□ Yes □ No □ Not sure
Get up/ready for school?	□ Yes □ No □ Not sure
Ride the school bus or navigate the TTC?	□ Yes □ No □ Not sure
Work at a desk without supervision?	□ Yes □ No □ Not sure
Take medication at school without being prompted?	□ Yes □ No □ Not sure
Practice self-care and hygiene (including toileting)?	□ Yes □ No □ Not sure