Manitoba
Department of Families

Date sent:_____

Community Living Psychiatry Service (CLPS)
Request for Consultation

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

1. **Part 1** to be completed by **Community Service Worker**.
2. **Part 2** consent MUST be signed by the **client or Substitute Decision Maker (SDM)** before the referral will be considered.
3. **Part 3** to be completed by the **Primary Care Provider** (physician/nurse practitioner).
4. **FAX completed form to 204- 940-1992** (please print clearly). **Completion of this form does not guarantee service.**

Part 1 – CSW **Client Information:**

Full Legal Name: _____ Preferred Name: _____

Gender: _____ ☐ Prefer not to disclose DOB: _____

Current Physical Address: _____ Mailing Address (if different): _____

City: _____ Province: _____ Postal Code:_____

Phone Number: _____ ☐ Cell ☐ Landline

Alternate Phone Number: _____ Alternate Contact Name: _____

Type of Residence:
☐ Residential Placement ☐ Home Share ☐ Family ☐ Independent ☐ Supported Independent Living

Manitoba Health Card Registration#(6 digit): _____ Personal Health ID#(PHIN)(9 digit): _____

Substitute Decision Maker:

☐ Self ☐ Relative ☐ PGTO Name: _____ Phone #: _____

Next of Kin Information:

Name: _____ Relationship: _____

Phone: _____ Email: _____

Program Contact Information:

Agency/Day Program/High School: _____ Email: _____

Type of Support: _____ Hours/Week: _____

Address: _____ City: _____

Community Service Worker (CSW) Contact Information:

CSW Name: _____ Region: _____

Phone #: _____ Fax #: _____

Other Professionals Involved:

Psychiatrist ☐ Yes ☐ No Psychologist/BPS ☐ Yes ☐ No Counsellor ☐ Yes ☐ No

Are there any other Professionals involved? If yes, please specify: _____

Do you require Language Interpretation Services? ☐ Yes ☐ No If yes, specify language: _____

Do you require ASL Interpretation Services? ☐ Yes ☐ No

Please describe reason for referral:

_____

_____

_____

_____

Reported Safety Concerns:

_____

_____

_____

_____

Any Other Concerns/Relevant Information:

_____

_____

_____

_____

Part 2 – Client or SDM

Consent for Information and Treatment

Full Legal Name: _____ Date of Birth: _____

Manitoba Health Card Registration#(6 digit): _____ Personal Health ID#(PHIN)(9 digit): _____

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. _____

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

Dated this _____ (date) of _____, 20_____

Signature of Client or Substitute Decision Maker: _____

Witness Signature: _____

Consent for Psychiatric Assessment/Treatment

I, _____ Date of Birth : _____

Provide permission for Community Living Psychiatry Services, of the Department of Families, Community Services and Supports, to provide the following:

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 recommendations/education.

Psychiatric Consultation Services:

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

Nurse Clinical 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 _____ (date) of _____, 20_____

Signature of Client or Substitute Decision Maker: _____

Witness Signature: _____

FAX completed form to 204- 940-1992

Part 3 – Primary Care Provider

CLPS Request for Consultation

This Section to be completed by Physician/Nurse Practitioner

Date: ______________________

Client Name: ____________________________________ DOB: ________________________

PHIN#: ____ MHSC #: _____________________

Physician / Nurse Practitioner Information:

Referring Physician: ____________________________________ Billing #: ______________________

Address: ____ Clinic Name: ________________________

Telephone: ______________________________________Fax: _______________________________

Medical Diagnosis/Relevant Medical History/Social History:

____

____

Current Medications (include Dosage) and Describe Changes if applicable:

____

____

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

____

____

Reason for Request:

____

Duration of Concerns (weeks/months/years): ____

Current Interventions Trialled (pharmacological):

____

NOTE: Please attach copies of relevant reports/discharge summaries/previous psychiatry/psychology assessments

Dated this _______________ (date) of ___________________________, 20____

Signature of Prescribing Physician / Nurse Practitioner: ____

- -

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

Prescribing Physician / Nurse Practitioner Name: ____

FAX completed form to 204- 940-1992