Fax: 905-522-1870
Phone: 905-522-9922
Ext 109

Complex Care System Planning Table—

Hamilton Community Care Planning Referral Form

The Complex Care System Planning Table Hamilton (CCSPT) is a committee made up of various Hamilton multi-sector agencies that are making their expertise available support services in Hamilton who are serving individuals with complex mental health and/or addictions needs. CCSPT has created two supporting process for the Hamilton community to gain access to the expertise and potential support for clients you are serving that usual care planning

1. Care Planning: you may request a care planning opportunity with the Complex Care System Planning Table (Hamilton) on behalf of an individual/family with complex and unmet needs. This process may be considered when agencies have had particular difficulty engaging other services in the support or care delivery to an individual or feel that they need input from other agency experts. Also, agencies, clients/families may be anticipating significant risks at transition periods; when an individual has a history of decompensating in the community and when the individual is frequently using emergency services, including hospital and crisis services.

Please note: this is a person-directed process with the expectation that the individual will be actively involved throughout the care planning (i.e. template summary, organization of meeting, invited participants, consent of final care plan, etc.). Please use the attached referral form to request care planning process.

2. Case Resolution/Consultation: In the case where an agency wants to access the expertise and input of other service agencies at CCSPT they can bring their client's situation forward for a non-identifying case discussion (case resolution) at the monthly CCSPT meetings. Meetings take place on the first Thursday of each month, and time has been put aside from 10 a.m.– 11:00 a.m. for these reviews. Please contact the CCSPT Co-chairs Satar Wahidi (swahidi@stjosham.on.ca) or Medora Uppal (muppal@ywcahamilton.org) to facilitate discussion of a client.

Please include the following information in your e-mail request: (also please feel free to use referral form)

- Referral Agency and primary staff contact information
- Description of individual's unique situation including the identification of the main reason for requesting meeting. This should be done in a non-identifying confidential manner i.e. no names or other identifying information.
- Identification of other agencies known to be involved or who the referring agency/client/family feel should be involved.

Referring agency will receive an email response back within two working days to discuss your email request and referral form for care planning, if applicable.

St. Joseph's Healthcare Hamilton-Mental Health & Addictions Program YWCA
Good Shepherd–Barrett Centre CMHA Womankind Hamilton Family Health Team
North Hamilton Community Health Centre Health Links COAST
Hamilton Health Sciences Southern Network of Specialized Care Shalem Mental Health Network
Wayside House ADGAS City of Hamilton Mission Services Indwell
Catholic Family Services Mental Health Rights Coalition

Fax: **905-522-1870**
Phone: **905-522-9922**
Ext 109

Complex Care System Planning Table—Hamilton

Community Care Planning Referral Form

Client Name: D.O.B	
Capacity for treatment decisions	Capable of making treatment decisions: ☐ Yes ☐ No Substitute Decision Maker: Contact:
Preferred language	
Consent	☐ Yes ☐ No Signed Consent Attached: ☐ Yes ☐ No
Primary reason for referral (severe behavioural problems, challenges connecting with services, refuses services and at risk, frequently visits ED or has had multiple hospital admissions or contact with service providers)	
Client Address: City: Postal Code: Phone: Message okay?	 ☐ Yes ☐ No
Type of housing and issues	
Income source and issues (adequate/ inadequate)	
Family Doctor Phone/Fax:	

Fax: 905-522-1870
Phone: 905-522-9922
Ext 109

Complex Care System Planning Table—Hamilton

Community Care Planning Referral Form

Specialists and contact information	
Medical History (include mental health)	
Substance Dependence/Misuse? (Current or history)	
Community agencies involved and primary contact	1. 2. 3. 4.
Legal/Justice services or involvement? Please describe.	
Referral Contact Information: Name: Agency: Phone:	
Please provide other relevant information.	
Fax Referral form and signed consent with any relevant assessments or notes	**YWCA Hamilton** **Attention: Medora Uppal c/o David Howson-Jan** **Confidential Fax: 905-522-1870** **PRINT FORM**
Office Use Only	**Date received:** **Complete:** **Contacted Referral Agency:** **Health Links: ☐ CCSPT: ☐ Geriatric: ☐**