

CTO Referral Process

All CTO referrals must be faxed to (905) 381-5612

The CTO referral process will start when completed documentation is received.

Referrals received within 2 weeks of discharge will not be accepted.

CTO Referral

- Physician order for CTO
- Social Worker to fax referral form/documentation to CTO Coordinator
- CTO Coordinator will review completed referral and contact referring Social Worker.

NOTE: Social Worker must ensure the Community Service Provider is in place prior to CTO referral and that they are agreeable to CTO at discharge.

Community Treatment Order Referral Form

Referrals received within 2 weeks of discharge date will not be accepted.

Client's Name:		Date of Referral: (dd/mm/yy)	
		M <input type="checkbox"/> F <input type="checkbox"/>	
Address:	Telephone:	Date of Birth: (dd/mm/yy)	AGE
	Marital Status:		
CTO Referring Psychiatrist/Physician		Referring Program/Service (physician/SW) Contact Name & Telephone:	
CTO Criteria			
SMI Diagnosis			
Has the client had 2 or more psychiatric hospitalizations in the last 3 years		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Has the client been hospitalized for 30+ consecutive days?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Has the client been the subject of a previous CTO?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Is the client aware of the CTO?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Is the client agreeable to the CTO?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Is the client competent to make treatment decisions?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
If not capable to consent: Date of capacity finding/F33			
Substitute Decision Maker NAME:			
Contact information (Address & Telephone) for SDM:			
Is the SDM aware of the CTO		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Is the SDM agreeable to the CTO?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Name of psychiatric follow up:			
SOC <input type="checkbox"/> Hamilton ACTT <input type="checkbox"/> Hamilton ACTT2 <input type="checkbox"/> HPS <input type="checkbox"/> CPC <input type="checkbox"/> HMHO <input type="checkbox"/> TOPSS <input type="checkbox"/> Other:			
Psychiatrist (if known):		Most Responsible Clinician:	
Have they been contacted regarding follow up at discharge?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Are they agreeable to the CTO at discharge?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Anticipated Date of Discharge: (dd/mm/yy)			
Documentation to accompany CTO Referral: (Referral received without accompanying documentation will not be processed)			
<ul style="list-style-type: none"> Admission note/history PES note Form 33/Incapacity re treatment (if applicable) Current Social Work History for this admission 		<ul style="list-style-type: none"> Transfer notes if from another facility Current medication profile Past discharge note (recent admissions - if available) 	
Please send completed referral form and documentation to:		For CTO Program Use Only:	
CTO Program		Original Referral – Complete:	
St. Joseph's Healthcare, Hamilton – West 5th Campus – D166		Date Received:	
Tel: (905) 522-1155, ext. 36321, Fax: (905) 905-381-5612		Notes:	