Brockville General Hospital

CONCURRENT DISORDERS STABILIZATION UNIT (CDSU) REFERRAL FORM

As of June 2022

Information about the Concurrent Disorders Stabilization Unit (CDSU)

- The CDSU is a 5-bed inpatient program at Brockville General Hospital (BGH) within Inpatient Mental Health and Addictions.
- The program is a 3 to 4 week stay with an average of 1-2 weeks of stabilization followed by 2 weeks of therapy including groups, individual work and support.
- The program is voluntary.
- Once accepted into the CDSU, patients may be required to wait for a bed to become available.
- Patients admitted to the program may meet with a peer support worker, physician or nurse practitioner prior to admission to hospital.
- The preadmission meeting will include a review of patient goals and a program overview. It may also include a medical assessment or lab testing.

Referrals are accepted directly from patients as well as from support providers including but not limited to nurses, nurse practitioners, physicians, mental health and addictions workers, counsellors, police, emergency medical services.

Questions regarding intake for the CDSU can be directed to the CDSU Intake Team at phone number 613-345-5649 ext. 52125

Referral Form

SECTION A:

- All parts of this section are required.
- It is to be completed by the patient (with the help of a support person if necessary)

SECTION B:

- This section is not required but helpful if completed.
- It can be completed by the patient (with the help of a support person if necessary) or their physician or nurse practitioner.

When complete, please fax all completed parts of the referral form to the BGH Bed Allocation Department at 613-345-8306.

ATTENTION: CDSU Intake Team

DATE FAXED: _____

NUMBER OF PAGES: _____

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PATIENT INFORMATION

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SECTION A (Required): Patient to Complete (can be completed with provider/support person)

PART 1 – PATIENT INFORMATION	
Name:_____ **Address:** _____ _____ **Phone:** _____ **May we leave a message?** Yes ☐ No ☐ **Date of Birth (YYYY/MM/DD):** _____ **Gender:** _____	**Do you have a family doctor or nurse practitioner?** Yes ☐ No ☐ **If yes: Doctor or NP Name:** _____ **Office Location (city):** _____ **Do you have a health card?** Yes ☐ No ☐ **If yes: Health Card Number:** _____ **Version Code:** ____
PART 2 – CONTACT INFORMATION	
If we can't reach you, is there someone we can contact to leave a message? Yes ☐ No ☐ **If yes: Name of Contact:** _____ **Relationship to You:** _____ **Contact Phone:** _____	**In case of emergency is there someone we can contact?** Yes ☐ No ☐ **If yes: Name of Contact:** _____ **Relationship to You:** _____ **Contact Phone:** _____
PART 3 – PATIENT QUESTIONAIRE	
What are your goals for attending this program?	
Describe your current drug and/or alcohol use:	

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Describe your mental health concerns:
Describe your physical health concerns:
Describe your social concerns (such as housing, finances, employment):
Describe your social and health care supports

Patient Name (please print): _____

Patient Signature: _____

Support Person Name: (if used): _____

Date form completed (YYYY/MM/DD): _____

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SECTION B: Can be completed by the patient, a physician or nurse practitioner.

PART 1 – INFORMATION SOURCE

This section has been completed by: Patient ☐ Doctor ☐ Nurse Practitioner ☐

Name of Doctor/Nurse Practitioner (please print): _____

Are you the patient's primary care provider? Yes ☐ No ☐

Telephone Number: _____ **Fax Number**: _____

PART 2 – ALLERGIES

Do you/they have allergies? Yes ☐ No ☐ Unknown ☐

If yes, please list:

PART 3 – MEDICATIONS

Do you/they have a regular pharmacy? Yes ☐ No ☐ Unknown ☐

If yes, Pharmacy Name: _____ **Pharmacy Location:** _____

Current Medications Name	**Dose/Amount**	**How often or frequency**	**Date Started**
Past Psychiatric Medications (last year) Name	**Dose/Amount**	**How often or frequency**	**Date Started**

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PART 4 – PATIENT AND FAMILY MEDICAL AND SURGICAL HISTORY

Please put a Y (Yes) or N (No) in the boxes below. If it is a family member, write their relationship to you.

Medical History Do you or have you had:	**Patient (Y or N)**	**Family Member (Y or N and Who)**	**Details**
High blood pressure			
Heart disease			
Diabetes			
Obesity			
Sleep Apnea			
Chronic Pain			
Skin Infections			
Known MRSA			
Head injury			
Fetal Alcohol Syndrome			
Other:			
Other:			
Other:			
Surgery History List any operations	**Patient (Y or N)**	**Family Member (Y or N and Who)**	**Details**
Mental Health History	**Patient (Y or N)**	**Family Member (Y or N and Who)**	**Details**
Anxiety			
Depression			
Bipolar			
Personality disorders			
Schizophrenia (or other psychosis)			
Self-harm/suicide (including attempts)			
Other:			
Other:			
Other:			

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Substance Use History	Patient (Y or N)	Family Member (Y or N and Who)	Details
Alcohol (beer, wine, liquor)			
Amphetamines or Methamphetamines (MDMA, speed, uppers, crystal)			
Barbiturates (phenobarb, seconal)			
Benzodiazepines (valium, xanax)			
Cannabis (marijuana)			
Hallucinogens (PCP, LSD)			
Opioids (morphine, fentanyl, oxy, heroin)			
Tobacco (smoking/vaping)			
Stimulants (cocaine, crack)			
Other:			

PART 5 – LEGAL INFORMATION

Do you have any outstanding charges? **Yes** ☐ **No** ☐ **Unknown** ☐

If yes, please describe:

PART 6 – ADDITIONAL INFORMATION

Please share any additional relevant information related to substance use, known or possible psychiatric diagnoses, current symptoms, emergency department visits, goals for assessment and treatment, etc.

Please attach any relevant lab results, diagnostic studies and consultation reports.