Brockville General Hospital

CONCURRENT DISORDERS STABILIZATION UNIT (CDSU) REFERRAL FORM

As of November 2024

This is a referral form for the Concurrent Disorders Stabilization Unit (CDSU). Referral forms are reviewed within 1-2 weeks of receipt, not on an immediate basis. Please note that this form is not intended to be used in the event of a mental health crisis or emergency. If you have immediate concerns about your mental health or the mental health of another individual, please call or text the Suicide Crisis Helpline at 988 or call 911 or go to the nearest emergency department.

Information about the Concurrent Disorders Stabilization Unit (CDSU)

- The CDSU is an inpatient program at Brockville General Hospital (BGH) within the Inpatient Mental Health and Addictions unit.
- Referrals are accepted directly from patients. Patients may ask for help to complete the form from support providers including but not limited to nurses, nurse practitioners, physicians, mental health and addictions workers, counsellors, police, emergency medical services.
- The program is a 2 week stay.
- The program is voluntary.
- Patients are supported by a team including nurses, a nurse practitioner, a peer support worker, a concurrent disorders specialist, medical doctors, occupational therapists, a dietitian and other providers.
- Prior to admission to the program, patients may meet with a peer support worker, physician or nurse practitioner. The preadmission meeting will include a review of patient goals and a program overview. It may also include a medical assessment or lab testing.
- If you will be late or unable to arrive for your scheduled admission, please contact the CDSU Intake Team at 613-345-5649 extension 52125. If you do not contact the intake team prior to your admission time, your file will be closed and you will need to complete a new referral.
- Electronic devices including cell phones, radios and laptops are stored away from patient's rooms. You can schedule a time to use your devices each day, for a ½ hour per day. A phone is available for short local and long-distance phone calls at no cost.
- BGH is a smoke-free and vaping-free environment. Nicotine replacement therapy will be provided. As well, we can help you access nicotine replacement in the community after discharge.
- Cigarettes, vapes, drugs and alcohol **CANNOT** be consumed on the unit. Storing or using cigarettes, vapes, drugs or alcohol in any form on the unit will result in discharge.
- Patients have a single room with private bathroom and shower.
- The unit is always locked. You will remain in the unit for the duration of your stay.
- Visitors are not permitted during admission.

ZERO TOLERANCE

BGH is committed to providing a safe environment for all our patients, visitors and staff. For the protection and respect of everyone, we **DO NOT ALLOW** any kind of violent or abusive behaviour, including physical or verbal aggression (swearing, threats, demeaning language, racial slurs). If anyone who is admitted to the CDSU becomes physically or verbally aggressive, violent or threatening, they will be discharged from the program **IMMEDIATELY AND WITHOUT WARNING**.

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GUIDELINES FOR COMPLETING THIS FORM

1. The referral form can be completed by the patient with the help of a health care provider, or a support person.
2. All parts of the form must be completed.
3. The patient **MUST** have a valid Ontario Health Card to be admitted to the unit. If you do not have a health card, our team can connect you with support to obtain one at a Service Ontario office.
4. If the referral is being sent from a health care providers office, please attach any relevant lab results, diagnostic studies and consultation reports.
5. If you have any concerns about your mental health or the mental health of another individual and you think immediate assistance is needed, please:
    - Call 911, or
    - Call or text the Suicide Crisis Helpline at 988
    - Go to the nearest emergency department
6. Questions regarding intake for the CDSU can be directed to the CDSU Intake Team at phone number 613-345-5649 ext. 52125

When complete, please fax all completed parts of the referral form to the BGH Inpatient Mental Health and Addictions Unit at 613-345-1127.

ATTENTION: CDSU Intake Team
DATE FAXED: _____
NUMBER OF PAGES: _____

Brockville General Hospital

PATIENT INFORMATION

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PART 1 – PATIENT INFORMATION

Name:_____

Address: _____

_____

Phone: _____

May we leave a message? Yes ☐ No ☐

May we text you at this number? Yes ☐ No ☐

Date of Birth (YYYY/MM/DD): _____

Gender Identity: _____

Preferred Pronouns:_____

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: ____

Do you have a regular pharmacy? Yes ☐ No ☐

If yes, Pharmacy Name: _____

Pharmacy Location: _____

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: _____

If we reach your contact, can we discuss with that individual:

1. **The information contained in this referral form** Yes ☐ No ☐
2. **Information about your planned admission including date, time and instructions** Yes ☐ No ☐

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PATIENT INFORMATION

PART # - PATIENT QUESTIONNAIRE

What are your goals for attending this program?

1.

2.

3.

Substance Use:

Substance	Amount	How Often	Length of Use (days, months, years)	Current Use (Yes/No) (If not current, indicate day of last usage)
Alcohol				
Cannabis				
Opioids				
Stimulants				
Other(specify)				

Do you have any treatment plans other than CDSU admission? Yes ☐ No ☐

If yes, please describe: _____

List, if any, your mental health diagnoses:

Do you see a counsellor, psychotherapist or case worker? Yes ☐ No ☐

If yes, name: _____

Do you see a psychiatrist? Yes ☐ No ☐

If yes, name: _____

Do you have any other mental health supports? Yes ☐ No ☐

If yes, name(s): _____

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PATIENT INFORMATION

ALLERGIES

Do you have allergies? Yes ☐ No ☐ Unknown ☐

If yes, please list:

CURRENT MEDICATIONS (complete below or attach a list your pharmacy)

Medication Name	Dose/Amount	How Often or Frequency	Date Started

Describe your physical health concerns:

Briefly describe the following:

- Your housing_____
- Your employment _____
- Your finances (OW, ODSP, work, pension, limited or none) _____
- Do you have any outstanding charges? Yes ☐ No ☐
  If yes, please describe any upcoming court dates or probation requirements:

Describe your social and health care supports (for example Lanark Leeds Grenville Addictions and Mental Health (LLGAMH), Probation Officer (PO), Change Health Care, Family)

PART 4 – ADDITIONAL INFORMATION

Please share any additional relevant information related to substance use, current symptoms, emergency department visits, recent hospital admissions etc. Please attach any further information on an additional page.

Patient Name (please print): _____

Patient Signature: _____

Support Person Name: (if used): _____

Date Form Completed (YYYY/MM/DD): _____/____/____