Health PEI
One Island Health System

Santé Î.-P.-É.
Un système de santé unique

REFERRAL FORM
Mental Health Intensive Day Program

902-288-1274
Monday to Friday 9 am – 3 pm

Please send referrals by:
Cerner Order: MHIDP Referral
Fax: 902-620-3108
Email: MHIDP@ihis.org

SERVICE OVERVIEW

The Mental Health Intensive Day Program (MHIDP) is a 4-week outpatient voluntary program (9am-3pm, Monday-Friday) designed to help individuals understand their mental health, reduce the impact of functionally debilitating symptoms and cope with challenging situational crises. The treatment mission is to develop a setting that provides the skills for recovery, helps a person gain a sense of hope and find purpose.

The program is designed for clients who are experiencing moderate to acute symptoms of a psychiatric diagnosis which do not necessitate an inpatient 24-hour hospitalization.

REFERRAL PROCESS

Referrals accepted by psychiatry and community mental health clinicians.
Once received, referrals are assessed for eligibility and suitability. The client will be contacted for an intake assessment within 1-4 days of receiving the referral. Please ensure correct and current contact information is provided.

ADMISSION ELIGIBILITY

- 18 years of age or older
- Has moderate to acute symptomology, but **does not** require 24-hour hospital admission
- Capacity and willingness to participate in a 4-week group treatment, psycho-educational program
- Can independently administer their personal medications
- Can commit to being substance-free during scheduled day programming
- Can function independently

EXCLUSION CRITERIA

- **Individual currently demonstrates an incapacity to engage program components (4 weeks/ group setting).**
- **Is imminently at risk of violence to self or others.**
- **Lacks sufficient impulse/behavioral control.**
- **Cognitive dysfunction that precludes integration of newly learned material, skill enhancement, or behavioral change.**
- **Currently experiencing psychotic symptoms or other states to such a degree that the individual may become more symptomatic in a predominantly group treatment setting.**
- **The individual has primarily housing, custodial, or respite needs. Clients must have their basic socio-economic needs met in order to have success in this program. Clients with these needs will be referred to a different Mental Health and Addictions program.**

MENTAL HEALTH INTENSIVE DAY PROGRAM REFERRAL FORM

REFERRAL SOURCE INFOMATION

Referring Psychiatrist / MH Clinician:

_____

Contact Number / email (preferred): _____

Date of referral: _____

By signing below, I am stating that the client is aware of this referral on their behalf and that the program descriptors, eligibility criteria, and referral process have been explained to the client.

Psychiatrist/ Clinician signature: _____

CLIENT INFORMATION

Name:_____

PHN: _____ Age: _____

Client's Address: _____

Telephone / cell: _____ Can an identifying message be left? _____

Alternate contact number: _____ Can an identifying message be left? _____

Client's email address: _____

Mental health diagnoses (Please provide any relevant conditions/diagnosis):

CLIENT PREPARDNESS

Please indicate why the client would benefit from the MHIDP:

Potential barriers that may prevent client from fully participating in MHIDP:

☐ No barriers	☐ Behavioral	☐ Housing	☐ Transportation
☐ Literacy Level	☐ Mobility	☐ Work	☐ Childcare
☐ Language	☐ Medical Condition	☐ Legal	☐ Other: