



DLM120

\_\_\_\_\_  
Name at birth

\_\_\_\_\_  
First name

\_\_\_\_\_  
File No.

**GUICHET D'ACCÈS EN SANTÉ MENTALE (GASM)–ADULTE  
REQUEST FOR SERVICE (partners)**

Note: The masculine form is used throughout the text for ease of reading, but refers to both men and women.

**Section reserved for GASM administrative use**

Territory associated: Métro site  Côte-des-Neiges site  Parc-Extension site

**IDENTIFICATION OF USER – *Mandatory information***

Family name: \_\_\_\_\_ First name: \_\_\_\_\_ Sex: F  M

Date of birth (yy-mm-dd): \_\_\_\_\_ Language(s) used: French  English  Other  : \_\_\_\_\_

Address: \_\_\_\_\_ Postal code: \_\_\_\_\_

Tel. no. where user can be reached: #1 ( ) \_\_\_\_\_ #2 ( ) \_\_\_\_\_

Contact person in case of need: \_\_\_\_\_ Relation: \_\_\_\_\_ Tel. no.: ( ) \_\_\_\_\_

Does the user have children aged under 18 years?: No  Yes  Their age: \_\_\_\_\_

Does the user live with his children? : No  Yes  Specify (e.g.: full custody, joint custody): \_\_\_\_\_

Is the user currently being followed by a general practitioner? No  Yes

Name of physician: \_\_\_\_\_ Name of clinic/GMF: \_\_\_\_\_ Tel. no.: ( ) \_\_\_\_\_

Have you contacted the user's general practitioner prior to submitting a request for service to the GASM? No  Yes

**REASON(S) FOR REQUEST FOR SERVICE (*check*)**

- First-line mental health evaluation and need for a general practitioner
- First-line mental health evaluation and return to attending general practitioner
- First-line mental health evaluation and follow-up by first-line mental health team or by another first-line program of the CSSS
- First-line mental health evaluation and joint follow-up by first-line mental health team or other first-line program of the CSSS
- Psychiatric evaluation<sup>1</sup>
- Other: \_\_\_\_\_

In submitting a request to the GASM-Adult, for what particular needs does the user or your organization require a response? What are the expectations of the user and/or your organization with respect to the care and services to be received?

\_\_\_\_\_  
\_\_\_\_\_

**CLINICAL OBSERVATIONS <sup>2</sup> associated with the request for service**

Describe the symptoms which are of concern to the user or to yourself (with respect to mood, thought and behaviour), the approximate date of their appearance, and their intensity (light, moderate, severe):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ASSOCIATED CIRCUMSTANCES and MANIFESTATIONS or TRIGGERS** *(check all that are applicable)*

- Suicidal thoughts: ..... Urgency/Severity..... low  moderate  high
- Homicidal thoughts: ..... Urgency/Severity..... low  moderate  high
- Onset of psychosis: ..... Urgency/Severity..... low  moderate  high
- Drug abuse: ..... Urgency/Severity..... low  moderate  high
- Alcoholism: ..... Urgency/Severity..... low  moderate  high
- Gambling problem: ..... Urgency/Severity..... low  moderate  high
- Trauma/abuse: ..... Urgency/Severity..... low  moderate  high
- Eating disorder: ..... Urgency/Severity..... low  moderate  high
- Conjugal problems (recent/imminent break-up): ..... Urgency/Severity..... low  moderate  high
- Employment problems: ..... Urgency/Severity..... low  moderate  high
- Housing problems: ..... Urgency/Severity..... low  moderate  high
- Migration problems: ..... Urgency/Severity..... low  moderate  high
- Other(s): \_\_\_\_\_ Urgency/Severity..... low  moderate  high

**PSYCHIATRIC ANTECEDENTS** *(if known)*

Indicate, for instance, past or current diagnosis/diagnoses, the approximate date of the appearance of the symptoms or illness, the approximate dates and duration of psychiatric hospitalizations, the presence or absence of suicidal thoughts or attempts in the past, the presence or absence of a psychiatric follow-up, the names of the professionals/caregivers involved with the user, and the presence of a family history:

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**MEDICAL ANTECEDENTS** *(if known)*

Indicate if user suffers or has suffered from physical health problems (diabetes, thyroid gland, etc.): No  Yes

If "Yes", specify: \_\_\_\_\_

Is user receiving treatment or has user received treatment? No  Yes  If "Yes", specify: \_\_\_\_\_

**PHYSICAL and/or PSYCHIATRIC MEDICATION** *(name, dosage, date first taken, side effects)*

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**SERVICES AND INTERVENTION PLAN**

What is the nature of the services your organization provides to the user (e.g.: follow-up, housing) and/or the aim of your intervention?

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**CONSENT TO SHARE PERSONAL INFORMATION**

I, the undersigned, \_\_\_\_\_ hereby consent that \_\_\_\_\_  
(name of user) (name of organization)

and the *Guichet d'accès en santé mentale – Adulte of the CSSS de la Montagne* exchange any personal information that will facilitate the continuity of the care and services offered to me or that I will receive. My consent is valid during the period in which I will receive care and services from these establishments or until I explicitly revoke it.

Date (yy-mm-dd): \_\_\_\_\_ Signature: \_\_\_\_\_

**IDENTIFICATION OF APPLICANT**

Name of applicant (in capital letters): \_\_\_\_\_ Name of organization: \_\_\_\_\_

Address of organization: \_\_\_\_\_ Postal code: \_\_\_\_\_

Tel. no.: ( ) \_\_\_\_\_ Fax no.: ( ) \_\_\_\_\_

⇒ Do you intend to accompany the user to the evaluation meeting at the GASM? No  Yes

⇒ Date of your next appointment or contact with the user (yy-mm-dd): \_\_\_\_\_

⇒ The user has been known to your organization since when? (yy-mm): \_\_\_\_\_

Date of application (yy-mm-dd): \_\_\_\_\_ Signature of applicant: \_\_\_\_\_

<sup>1</sup> No psychiatric evaluation for medical or legal purposes will be conducted at the GASM or the M.E.L. (e.g., return to work, insurance, SAAQ, social aid, etc.)

<sup>2</sup> If the mental state of the user requires an urgent psychiatric evaluation (e.g., severe psychosis, suicidal crisis with high risk), please direct the user to the psychiatric emergency. On the other hand, if the situation is more in the nature of a psychosocial crisis, with or without the presence of suicidal thoughts or other psychiatric symptoms, please direct the user to the Accueil Évaluation Orientation (AEO) service of the CLSC and/or to the Crisis Centre (housing/lodging and crisis follow-up, 24/7 telephone support). (Refer to introductory page for coordinates.)

**How to submit the request for service form :**  
GASM  
Fax : 514 380-5515  
Telephone : 514 731-1386, ext. 2281  
Hours : 9 A.M. to 5 P.M., Monday to Friday, including holidays