Jewish General Hospital

Elspeth McConnell Mental Health and Wellness Centre
Trauma-Focused Therapy Program
Referral Sheet

Integrated Health and Social Services University Network for West-Central Montreal
Québec

Date of Referral: _____

Patient Name: _____ Patient MRN: _____

Medicare: _____ DOB: _____ M___ F___ NB___

Telephone Number: _____ Voicemail ☐ En___ Fr___All___

Address: _____ Postal Code: _____

Referring Physician:_____ Service: _____

Telephone / Email:_____ Signature:_____

Community Resources/Professionals Involved: _____

I can continue to follow this patient during and after their time in the TFT Program ☐

Psychiatric Diagnoses	Medications	Relevant Medical Conditions

Reason for Referral / Current Problems:

_____

_____

ACE Score _____

Please check all that apply:

Inclusion criteria		Exclusion criteria	
History of trauma, childhood or adult		Unstable housing	
If childhood trauma, ACE $\geq$ 4		Recent psychiatric admission (within 3-6 months)	
Symptoms of PTSD or complex PTSD (difficulties with emotional regulation & interpersonal relations)		Active suicidality or homicidality	
Motivation for psychotherapy		Unstable substance use disorder	
		Unstable eating disorder	
		Unstable medical condition	
		Current ongoing abusive relationships	

Referrals can be sent to: Email: **elspethmcconnell.centre.ccomtl@ssss.gouv.qc.ca**
Fax (internal): **28290**
Fax (external): **514-340-8290**

For further questions: Telephone: **514-340-8222, ext. 25633**

Hôpital général juif

Adverse Childhood Experience (ACE) Questionnaire

Centre intégré universitaire de santé et de services sociaux du Centre-Ouest-de-l'Île-de-Montréal
Québec

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** ...
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** ...
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**...
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that ...
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that ...
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother/father or stepmother/stepfather:
   Often pushed, grabbed, slapped, or had something thrown at them?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score