island health

MENTAL HEALTH & SUBSTANCE USE INTAKE REFERRAL FORM (FOR PATIENTS 19+)

Fax ATTN: MHSU Clinicians
1-250-538-4877

PLEASE PRINT LEGIBLY PATIENT INFORMATION

Name: *last*_____ *first*_____ *alias?:* _____ Gender: M ☐ F ☐ Other ☐

DOB (dd-mm-yyyy): ___-___-_____ PHN: 9_____ Address: _____

MRN #: _____ Phone # *Home*: _____ *Work/Other*: _____

REFERRAL INFORMATION

Date of Referral: _____ Source of Referral: _____

Primary Care Provider: _____ Phone: _____ Private Line: _____ Fax: _____

Date of last physical exam: _____ Is patient supportive of this referral? Y ☐ N ☐

REASON FOR REFERRAL

WHY IS THIS PATIENT SEEKING MENTAL HEALTH OR ADDICTION SERVICES?

CURRENT CLINICAL FEATURES - *Please check all that apply*:

Risk Factors:

- ☐ Risk of harm to others ☐ plan? _____ ☐ means available
- ☐ Risk of harm to self ☐ plan? _____ ☐ means available
- ☐ Suicide attempt history ☐ method _____
- ☐ Recent actions taken to a suicide/homicide plan (e.g. writing will, procuring means, giving away belongings)
- ☐ Behaviour influenced by delusions/hallucinations
- ☐ Patient is experiencing command hallucinations
- ☐ Pronounced Self Neglect
- ☐ Serious complicating medical problem? _____

Please describe any risk factors identified:

*** IF PATIENT'S RISK REQUIRES A RESPONSE TODAY, PLEASE REFER TO IMCRT (MOBILE CRISIS TEAM 361-5958 after 1300 hrs Confidential Pager for professionals only) OR TO THE EMERGENCY ROOM, OR CALL 911.**

- ☐ Pronounced and/or Resistant Depression
- ☐ Psychotic Symptoms
- ☐ Manic/Hypomanic Symptoms
- ☐ Major Cognitive Impairment/Disorganization
- ☐ Unstable/Lack of Housing
- ☐ Other: _____
- ☐ Chronic Emotional/Behavioural Instability
- ☐ Generalized Anxiety
- ☐ Panic Attacks
- ☐ Social Phobia
- ☐ Obsessive/Compulsive Behaviours
- ☐ Other: _____

Significant Drug/Alcohol Abuse? (Please mark below)

Substance	Typical Method	Quantity	Frequency
1.			
2.			
3.			
4.			

Previous/Current Treatments: (Including psychiatric admissions & addictions services)

Type	Dose	Date
1.		
2.		
3.		
4.		

Medical History and Investigations: (Please attach investigation results)

1.
2.
3.
4.

PLEASE DESCRIBE CURRENT SYMPTOMS AND ANY COMPLICATING FACTORS:

CURRENT MEDICATIONS:
(Attach printout of current symptoms/medications from GP Chart if preferred)

Type Dose When Initiated

1._____
2._____
3._____
4._____
5._____
6._____

Any Adverse Drug Reactions? ☐ _____

Any Problem Affording Medications? ☐ _____

Any **Allergies?** ☐ _____

TO BE COMPLETED BY MHAS ADMINISTRATIVE STAFF:

Systems Checked:
- ☐ CERNER
- ☐ MH Intake Tracking System
- ☐ PM Office
- ☐ MHDB
- ☐ Powerchart reviewed by clinician

TO BE COMPLETED BY INTAKE STAFF:

Message Log:

To Whom When M/L Staff Signature

_____
_____
_____

Please fax this form and the completed Patient Questionnaire to:

FAX:1-250-538-4877
Lancer Building
PHONE:1-250-538-4711
#202-323 Lower Ganges Road, Salt Spring Island, BC V8K 2V4