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

PLEASE PRINT LEGIBLY - FAX all pages to 250-370-5724.

PATIENT INFORMATION – if this information is not completed the referral will not be processed

Name: *Last*_____ *First*_____ *Preferred name*_____

Sex: Female ☐ Male ☐ Intersex ☐ Prefer Not to Answer ☐ **Gender:** Woman/girl ☐ Man/boy ☐ Non-binary ☐ Unknown

DOB (dd-mm-yyyy): _____ **PHN:** 9_____ **MRN #:** _____

Phone #: *Primary*: _____ *Secondary*:_____ *Ok to leave messages?* Y ☐ N ☐

Address: _____

E-mail address (optional): _____

REFERRAL INFORMATION – if this information is not completed the referral will not be processed

Date of Referral: _____

Referring Physician: _____

Referring Clinic: _____

Clinic Phone: _____ Fax: _____

Medical Professionals Line: _____

Best time to reach referring Physician:_____

Place Sticker Here

Primary Care Physician (if different from referring physician): _____

If the patient is referred to Psychiatry or CBT Skills Group are you willing to remain MRP? Y ☐ N ☐

CURRENT CLINICAL FEATURES – Please check all that apply, then provide any additional information:

URGENCY

- ☐ Non-Urgent / Routine
- ☐ Semi-Urgent / Moderate
- ☐ Urgent – *IF RISK REQUIRES AN IMMEDIATE RESPONSE, PLEASE REFER TO IMCRT (MOBILE CRISIS TEAM) via Confidential Pager for professionals only **250- 361-5958** after 1300 hours OR TO THE EMERGENCY ROOM, OR CALL 911.*

HIGH-RISK SYMPTOMS

- ☐ Risk of harm: ☐ To self ☐ Others ☐ Plan?
- ☐ Suicide / homicide risk assessment completed by referring physician?
- ☐ Psychotic Symptoms
- ☐ Behaviour influenced by delusions/hallucinations
- ☐ Patient is experiencing command hallucinations
- ☐ Substance Use – increased and/or excessive
- ☐ Falls/mobility risks
- ☐ Child protection concerns; MCFD contacted? _____

SYMPTOMS

- ☐ Pronounced and/or Resistant Depression
- ☐ Manic/Hypomanic Symptoms
- ☐ Major Cognitive Impairment/Disorganization
- ☐ Suicide attempt history
- ☐ Chronic Emotional/Behavioural Instability
- ☐ Generalized Anxiety
- ☐ Panic Attacks
- ☐ Social Phobia
- ☐ Obsessive/Compulsive Behaviour

Assessments primarily for ADHD and Autism spectrum disorders not provided by this clinic.

SYMPTOM DETAILS, HISTORICAL CONTEXT, CURRENT STRESSORS:
Click here to enter text.

REASON FOR REFERRAL

PREVIOUS MHSU SERVICE HISTORY: ☐ Within IH ☐ Elsewhere:_____

LIST MHSU SUPPORT SERVICES PREVIOUSLY OR CURRENTLY RECEIVING:
Click here to enter text.

REFERRING PHYSICIAN SUSPECTED DIAGNOSIS:
Click here to enter text.

IF KNOWN, TYPE OF MHSU SUPPORT SERVICE SEEKING:

☐ Psychiatric Referral
☐ Single Session Therapy
☐ Mental Health Counselling
☐ Substance Use Counselling
☐ Detox
☐ Other: _____

Is patient supportive of this referral? Y ☐ N ☐
Would patient like to receive service in the Westshore? (MHSU Westshore service is for mild/moderate needs only) Y ☐ N ☐

MEDICATIONS

Name	Date started	Amount	Frequency
Click here to enter text.			

Adverse reactions/Allergies?
Click here to enter text.

Problems affording Medications?
Click here to enter text.

SUBSTANCE USE

Substance	Date last used	Amount	Frequency
Click here to enter text.			

Is there withdrawal/seizure risk due to use of alcohol and/or benzodiazepines?
Click here to enter text.

Please send along with all relevant EMRs, medication lists, consults, test results, and medical/psych history to 250-381-3222.

Physicians can consult with a Mental Health & Substance Use Intake worker by calling 250-519-3485.

MHSU CLIENT QUESTIONNAIRE

TO BE FILLED OUT BY PATIENT OR CAREGIVER
PLEASE PROVIDE AS MUCH INFORMATION AS YOU FEEL COMFORTABLE/SAFE SHARING
MUST ACCOMPANY PHYSICIAN MHSU INTAKE REFERRAL FORM

BACKGROUND INFORMATION FOR PSYCHIATRIC ASSESSEMENT
Patient Name:_____ **Date of Birth:**_____
What is your understanding of why you have been referred to psychiatric services by your family physician or nurse practitioner and what do you hope to get from an assessment: Click here to enter text.
Place of birth and where did you grow up: Click here to enter text.
Highest Level of education: Click here to enter text.
Source of Income: Click here to enter text.
Information about employment (type of work, hours, retired, etc.): Click here to enter text.
Relationship status (how long, concerns, etc.): Click here to enter text.
Housing (stable housing, own or rent, etc.): Click here to enter text.
Children (number and ages): Click here to enter text.

History of mental health or substance use services (when, how long, where, etc.): Click here to enter text.
Previous psychiatry/previous diagnosis (when, where, what, etc.): Click here to enter text.
Substance use, including alcohol, tobacco, cannabis, street drugs, misuse of over-the-counter medication, misuse of prescription medication (including how much, how often, route of injection, etc.): Click here to enter text.
Physical health concerns: Click here to enter text.
Previous or current legal issues: Click here to enter text.
History of trauma/abuse: Click here to enter text.
Family history of mental health or substance misuse concerns (diagnosed or suspected): Click here to enter text.