

Child and Adolescent Psychiatry Program (CICAPP) Child Youth and Family Mental Health (CYFMH)

Intake Referral Form

MANDATE

- The primary mandate of Child and Adolescent Psychiatry Program (CICAPP) is to provide tertiary services to children, youth and their families throughout Central Vancouver Island within the catchment area that lies between Ladysmith, Bowser and Port Alberni.
- In most cases it is expected that mental health assessment and treatment has been initiated and referrals are made due to a need for a more specialized psychiatric assessment.
- The ongoing involvement of community physicians and mental health professionals is essential to support the continuing needs of these clients. Our goal is to communicate with families and involved professionals throughout our process of assessment and we encourage you to contact us.

REFERRAL PROCESS

- 1. Complete the two page form (please print clearly) and fax to 250-755-7946. The consent should be signed by the legal guardian and/or child 12 years and older before the referral will be considered.
- 2. If you wish to discuss the referral before submitting, phone Intake at 250-755-7945.
- Additional documentation in regard to program admission criteria may be requested. Relevant reports and assessment documents must be faxed to CICAPP Intake at: 250-755-7946. Eligibility criteria exist for CICAPP.
- 4. Completion of this form does not guarantee service.

Patient Information:						
Full Legal Name:						
Preferred Name:					DOB:	
Current Address:				ров.		
City:			nce:	Postal (Code:	
Gender: Prefer not to disclose		Phone		Cellular:		
Family Physician:		1 110110	· · · · · · · · · · · · · · · · · · ·		· ysical Exam:	
Provincial Health Number:		Schoo	<u>-</u>		Phone:	
		Scrioc	л.		i none.	
Parent/Guardian Information:						
Legal Guardian Name:						
Current Address:				Relationship:		
City:		Provin	nce:	Postal Code:		
Phone: Child resides w		vith:		Relationship:		
Consent:						
I(Legal Guardian) and					(Child/Youth 12 years	
and older) give consent for CYFMH / CICAPP employees to receive and share information related to the						
mental health assessment and treatment needs of: with other profession						
in order to facilitate the provision of continuing care.						
Signature of Legal Guardian:				Date:		
Signature of Child:			Date:			
Signature of Witness:			Date:			
Referring Physician:						
Referring Physician:				Billing N	Number:	
Current Address:				1		
City:		Provir	vince: Postal Code:		Code:	
Phone:			Fax:			



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MEDICAL DIAGNOSIS / RELEVANT MEDICAL HISTORY & CURRENT MEDICATIONS (include dosage):						
ARE THERE ANY CURRENT SAFETY CONCERNS? Please specify:						
☐ Self-harm ☐Suicid	dal ideation Aggressi	on □Suicide Attempts				
What is the reason for this referral: (Please specify or attach a separate sheet if necessary.)						
Has this patient been referred to an	y other programs? If yes, please spe	ecify:				
Other Involved Professionals:						
☐ Pediatrician:						
☐ Psychiatrist:						
□ Psychologist:						
☐ Counsellor:						
☐ Community Mental Health Team:						
☐ Are there any other professionals involved? (if yes, please specify):						
What are the presenting concerns? (Please check all that apply)						
☐ Anger/Oppositional Behaviour	☐ Hallucinations/Delusions	☐ Peer Relationship Difficulties				
☐ Anxiety	☐ Hyperactivity	☐ School Difficulties				
☐ Behaviour/Dysregulation	☐ Inattention	☐ Sleep Problems				
☐ Depression/Mood	☐ Learning Difficulties	☐ Substance Abuse				
☐ Developmental Delay	☐ Obsessions/Compulsions	☐ Other:				
Please provide details on severity of the psychiatric concern and the effect on the patient's functioning (please attach copies of relevant reports):						
How can we best meet this client's cultural and/or spiritual needs?						
Tiew out we best meet this offent's editoral and/or spiritual needs:						
Please indicate who will be following up with this patient after tertiary level service is completed:						
Prescribing Physician (if indicated):						
2. Community Clinician/Case Manager:						