Child Youth & Family Mental Health Services
Queen Alexandra Centre for Children's Health
2400 Arbutus Road Victoria BC V8N 1V7

Ledger Comprehensive Assessment Program (CAP) Referral Form

MANDATE

Ledger comprehensive assessment program is a regional tertiary level service which provides inpatient multi-disciplinary assessment and treatment initiation services to children, youth and their caregivers. It is expected that mental health assessment and treatment has been initiated in the home community and referrals are made due to a need for more intensive multidisciplinary assessment and/or treatment planning on an inpatient basis. Our goal is to communicate with caregivers and involved professionals throughout our process of assessment and treatment initiation and we encourage you to contact us.

ELIGIBILITY CRITERIA

- 16 years and below (up to 17th birthday).
- Children/youth with complex psychiatric challenges whose needs have exceeded the resources of their community.
- Ongoing involvement of community physicians and mental health professionals is essential (must have a case manager).
- Admissions are voluntary – child/youth and caregivers must be willing to participate in service.
- Medically stable.

REFERRAL PROCESS

1. **Complete this 3 page form (please print) and fax to Intake at 250-519-6789.**
2. **Ensure all information is filled out as completely as possible.**
3. **The consent portion of this form must be signed by the legal guardian and child/youth 12 years and older before the referral will be considered.**
4. If you wish to discuss the referral before submitting, phone Intake (250) 519-6720 or (250) 519-6794.
5. Include any collateral documentation, relevant reports, etc. and fax to Intake at 250-519-6789.

Referral Source – Referring Physician or Mental Health Clinician		
Name:		**Phone #:**
Address:		**Fax #:**
Patient Information		
Full Legal Name:		
Preferred Name:		**DOB:**
Current Address:		
City:	**Province:**	**Postal Code:**
	Phone #:	**Cell #:**
Gender: ☐ **Female** ☐ **Male** ☐ **x Gender** ☐ **Prefer not to disclose**		**Preferred pronoun:** ☐ **She/her** ☐ **He/him** ☐ **They/them**
Do you self-identify as Indigenous? Yes ☐ **No** ☐		
PHN:	**School:**	**School Phone #:**
Parent/Guardian Information		
Legal Guardian Name:		**Relationship to Patient:**
Current Address:		**Phone #:**
City:	**Province:**	**Postal Code:**
Patient resides with (if different):		**Relationship to Patient:**

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Consent *To Be Signed By Legal Guardian & Youth 12 Years and Older*

I _____*(Legal Guardian)* and _____*(Child/Youth 12yrs+)*
Give consent to CYFMHS employees to receive and share information related to the mental health assessment & treatment needs of _____ with other professionals in order to facilitate the provision of continuing care.

Signature of Guardian: _____ **Date Signed:** _____

Signature of Child/Youth: _____ **Date Signed:** _____

Signature of Witness: _____ **Date Signed:** _____

Referral Information

What is the reason for <u>this</u> referral? Please specify: Diagnosis/Relevant Medical History & Impact on the patient's functioning

Reason for referral:

☐ Diagnostic Clarification ☐ Medication Review

☐ Multidisciplinary assessment ☐ Psychology ☐ OT ☐ Speech & Language ☐ Community/School consultation

Are there any current safety concerns? Please specify:

☐ **Self Harm** ☐ **Suicidal Ideation** ☐ **Aggression** ☐ **History of Violence Alert** ☐ **Other(specify):**

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What are the PSYCHIATRIC CONCERNS? Please check ALL that apply		
☐ Anger/Oppositional behaviour	☐ Hallucinations/Delusions/Psychosis	☐ Peer Relationship Difficulties
☐ Anxiety	☐ Hyperactivity	☐ School Difficulties
☐ Behaviour/Dysregulation	☐ Inattention	☐ Sleep Problems
☐ Depression/Mood	☐ Learning Difficulties	☐ Substance Use
☐ Developmental Delay	☐ Obsessions/Compulsions	☐ Other (please describe)

Current Medications (including dosage):

How can we best meet this patient's cultural and/or spiritual needs?

Has this patient seen any of the following? If yes, please specify name and contact information:

	Date	Clinician	Still involved Yes/No
☐ Family Physician:			
☐ Pediatrician:			
☐ Psychiatrist:			
☐ Psychologist:			
☐ Counsellor:			
☐ Community Mental Health Team:			

☐ **Other professionals or programs involved? If yes, please specify name and contact information:**

Please indicate who will be following up with this patient after Ledger admission is completed:

Prescribing Physician (if indicated): _____

Community team/Case Manager/Lead: _____

Incomplete referrals will not be processed and will be returned to the referring clinician for completion.
Fax completed form to 250-519-6789.