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

PLEASE PRINT LEGIBLY- Page 1 and 2 of this form are to be completed by the referring Physician. Page 3 is to be completed by the client. FAX all pages to 250-381-3222.

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

Name: *last*_________________________ *first*__________________________ *Preferred name:* ___________________

Gender: M ☐ F ☐ Other ☐ DOB (dd-mm-yyyy): _______________

PHN: 9____________________ MRN #: ___________________________

Phone # *Primary*: _____________________ *Secondary*: ___________________________ *Ok to leave messages?* ______________

Address: ____

E-mail address (optional): ____

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

Date of Referral: ___________ Referring Physician: ______________________ Name of referring Clinic: _____________________

Clinic Phone: __________________ Medical Professionals Line: _______________________ Fax: _______________________

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

Is patient supportive of this referral? Y ☐ N ☐

Would patient like to receive service in the WestShore? (MHSU West Shore service is for mild/moderate needs only) Y ☐ N ☐

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

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

HIGH-RISK SYMPTOMS - if any of the boxes are checked please provide details to the right

☐ 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
☐ Unstable/Lack of Housing
☐ Suicide attempt history
☐ Chronic Emotional/Behavioural Instability
☐ Generalized Anxiety
☐ Panic Attacks
☐ Social Phobia
☐ Obsessive/Compulsive Behaviour

Please add details:

Click here to enter text.

URGENCY

☐ Semi-Urgent / Moderate
☐ Non-Urgent / Routine

******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.*

CURRENT STRESSORS

Click here to enter text.

REASON FOR REFERRAL

WHY IS THIS PATIENT SEEKING MENTAL HEALTH OR SUBSTANCE USE SERVICES?

Click here to enter text.

TYPE OF SERVICE REQUESTED: (Psychiatry, Single Sessions Therapy, Mental Health Counselling, Substance Use Counselling, Detox)

Click here to enter text.

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.			

Withdrawal/seizure risk?

Click here to enter text.

Please have client complete page 3 and send all pages 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.

MENTAL HEALTH & SUBSTANCE USE CLIENT QUESTIONNAIRE (FOR PATIENTS 19+)

This information may be shared with your family doctor and used within Island Health to provide you with the best possible care.

Name: ________________________ Alias? ______________________ Today's Date: ____________________

Gender: ________________________ Date of Birth: ______________ PHN (care card): 9________________

Address: ____

Primary Phone #: ____________________ Best time to call? _____________ OK to leave message? _____________

Family Physician: _____________________________________

What would you like help with the most? (ex. mental health concerns, stressors, substance use)

Which type of service are you requesting? (please circle)

Detox or Stabilization *Substance Use counselling (AOT)* *Psychiatry*

Mental Health counselling *Not sure* *Other:* ________________________________

Indigenous Identity: ___________________ Marital Status:_______________Employment Status:___________________

Source of Income:______________________ Other services or support involved?_________________________________

Education level?______________________ Legal involvement? ____

Has violence been an issue in your life? If Yes How?____

Children in the home?

What are your goals regarding your substance use and/or mental health?

Do you have any medical concerns we should be aware of?

Do you have problems with mobility (e.g. walking)?
YES NO

Are you at immediate risk of harming yourself or others?
YES NO

Are you able to remain safe? YES NO

SUBSTANCE USE

Substance	Date last used	Amount	Frequency

MEDICATIONS

Name	Date started	Amount	Frequency