Developmental Disability Mental Health Team
Mental Health and Substance Use
203-3939 Quadra Street Victoria, BC V8X 1J5
Phone 250-519-3519 Fax 250-519-3518
www.viha.ca/mhas

Medical Referral for DDMHT Psychiatric Assessment

Date of Referral: ___________________

Client Name: DoB: PHN:

Referral question/reason(s):

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Please check all that are relevant:

- ☐ Suicidal
- ☐ Homicidal
- ☐ Violent/Aggressive
- ☐ Child Abuse
- ☐ Substance misuse
- ☐ Allergy Alert
- ☐ Serious medical condition
- ☐ Other concerns (Please list below)

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CURRENT SYMPTOMS

- ☐ Changes in Sleep
- ☐ Changes in appetite
- ☐ Changes in concentration
- ☐ Changes in energy
- ☐ Hallucinations/delusions
- ☐ Drug/alcohol misuse
- ☐ Functional decline
- ☐ Other
- ☐ Self–injurious behaviour
- ☐ Medication side-effects
- ☐ Aggression

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Date of last office visit:_______________

Height:_______________ Weight:______________ BP___________ Waist Circumference:________________

Date Information taken: ______________

Please list current Medications (or attach list)

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Provider Signature:________________________________ MSP Billing#: _______________

Please Print Provider name: _______________________________