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

Request for Medical Referral for Psychiatric Appointment to
DDMHT Child & Youth Consultation Service

Dear Provider,

DDMHT Child and Youth Consultation Service is a collaborative service, designed to provide one-time psychiatric assessment of children & youth age 5 – 19 with special needs (ASD, FASD, CP etc) that currently do not have access to or do not meet eligibility requirements for DDMHT, VIHA Child and Adolescent psychiatry services, or MCFD/ CYMH services.

The patient being to this service will be seen by our Child and Adolescent Psychiatrist, Dr. Gisele Ferguson, MSP 66448.
As the primary care provider, you must be in favour of the Consultation to proceed.

If you support this consultation, please complete and return this Psychiatric Assessment Referral form with any supporting documentation to us by mail at the above address, or by **fax at 250-519-3518**

Patient NAME: _____ DOB: _____

PHN: _____

- Date last seen by Primary Care Provider _____
- Height _____ Wt. _____ BP _____Waist Circumference _____
- Date above information taken _____
- Please state your referral question:

Please also include:

- Copy of current medications including when started and PRNs and side effects
- Any Allergies
- Copies of any laboratory test results, medication changes and specialist's reports.

Provider Signature _____ MSP Billing # _____ Date _____

Print Provider name: _____

The direct medical care and prescribing will remain in the hands of the family physician, nurse practitioner or paediatrician.

You will be supplied with a copy of the reports and recommendations that follow from this review.

ACTION REQUIRED – PROVIDER PLEASE SIGN AND SEND
TO DDMHT WITH SUPPORTING DOCUMENTATION