Intake Referral Form

Child Youth & Family Mental Health Services
Queen Alexandra Centre For Children's Health

Service requested by Child/Youth, Family & Community:

☐Inpatient ☐Outpatient ☐Parent Connect (for CYFMHS use only)

MANDATE

- The primary mandate of Child, Youth & Family Mental Health Services is to provide tertiary services to children, youth and their families throughout Vancouver Island and the Gulf Islands.
- In most cases 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 on an inpatient or an outpatient basis.
- 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 treatment and we encourage you to contact us.

REFERRAL PROCESS

1. **Complete two-page form (please print) and fax to (250) 519-6789. The Consent must be signed by the legal guardian and child 12 years and older before the referral will be considered.**
2. If you wish to discuss the referral before submitting, phone Intake (250) 519-6720 or (250) 519-6794 or Ledger Reception (250) 519-6908.
3. Additional documentation in regard to program admission criteria may be requested. Relevant reports and assessment documents must be faxed to CYFMHS Intake (250) 519-6789. **Eligibility criteria** exist for all programs
4. Please make requests for **urgent** inpatient admissions directly by phoning (250) 519-6720 or (250) 519-6794

Patient Information:

Full Legal Name:		
Preferred Name:	DOB:	
Current address:		
City:	Province:	Postal Code:
Gender: ☐ Prefer not to disclose	Phone:	Cellular:
Family Physician:	Last Physical Exam:	
Provincial Health Number:	School:	Phone:

Parent/Guardian Information:

Legal Guardian Name:		
Current address:		Relationship:
City:	Province:	Postal code:
Phone:	Child resides with:	Relationship:

Consent:

I_____(Legal Guardian) and_____(Child/Youth 12 years and older)
Give consent for CYFMHS employees to receive and share information related to the mental health assessment and treatment needs of:

_____with other professionals in order to facilitate the provision of continuing care.

Signature of Legal Guardian:_____Date:_____
Signature of Child:_____Date:_____
Signature of Witness:_____Date:_____

Referring Physician or Mental Health Clinician Information:

Referring physician/MH Clinician name:		
Billing number:		
Current address:		
City:	Province:	Postal Code:
Phone:	Fax:	

This form can be completed by a physician or mental health clinician only; completion of this form does not guarantee service

Has this patient been referred to any other programs? If yes please specify:	
What is the reason for this referral: Please specify:	
☐Diagnostic clarification	☐Medication review
☐Multidisciplinary assessment ☐Psych ☐OT ☐Speech & Language	☐Community/School consultation
Outpatient only: ☐Family work/support ☐Individual/Family treatment	**Special Care Unit only:** ☐Stabilization
ARE THERE ANY CURRENT SAFETY CONCERNS? Please specify:	
☐Self-harm ☐Suicidal ideation ☐Aggression	

Referral Information:

Has this patient seen any of the following? (if yes please specify name and contact information):
☐Pediatrician:
☐Psychiatrist:
☐Psychologist:
☐Counsellor:
☐Community Mental Health Team:
☐Are there any other professionals involved? (if yes, please specify):

What are the PSYCHIATRIC CONCERNS? (Please check all that apply)

☐Anger/Oppositional behaviour	☐Hallucinations/Delusions	☐Peer Relationship Difficulties
☐Anxiety	☐Hyperactivity	☐School Difficulties
☐Behaviour/Disregulation	☐Inattention	☐Sleep Problems
☐Depression/Mood	☐Learning Difficulties	☐Substance Abuse
☐Developmental Delay	☐Obsessions/Compulsions	☐Other (please describe)

PLEASE PROVIDE DETAILS ON SEVERITY OF THE PSYCHIATRIC CONCERNS AND THE EFFECT ON THE PATIENTS FUNCTIONING (please attach copies of relevant reports):

DIAGNOSIS/RELEVANT MEDICAL HISTORY & CURRENT MEDICATIONS (including dosage):

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

Please indicate who will be following up with this patient after tertiary level service is completed:

1. **Prescribing Physician (if indicated):** _____
2. **Community Clinician/Case Manager:** _____

This form can be completed by a physician or mental health clinician only; completion of this form does not guarantee service