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

Fax completed form to Victoria CARES at 250-381-3222
If your client lives in the Western Communities catchment please fax to 250-370-5724

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

Name: Last_____ First_____ Preferred name _____

Sex: ☐ Female ☐ Male ☐ Intersex ☐ Prefer Not to Answer **Gender:** ☐ Woman/girl ☐ Man/boy ☐ Non-binary ☐ Unknown

DOB (dd-mm-yyyy): _____ **PHN:** _____ **MRN:** _____

Phone #: Primary: _____ Secondary:_____ Ok to leave messages? Y ☐ N ☐

Address: _____

E-mail address: _____ we email if not reachable by phone; we also send surveys.

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

Date of Referral: _____

Referring Primary Care Provider: _____

Referring Clinic: _____

Clinic Phone: _____ Fax: _____

Medical Professionals Line: _____

Best time to reach referring provider:_____

Sticker or stamp here

Primary Care Provider (if different from referring provider): _____

If patient is referred to psychiatry, are you willing to provide follow-up care based on psychiatric recommendations? Y ☐ N ☐

Is patient supportive of this referral? Y ☐ N ☐

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

URGENCY:

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

IF RISK REQUIRES AN IMMEDIATE RESPONSE, PLEASE CONTACT THE CRISIS & TRANSITION TEAM (Direct Professional Line: 250-370-5657, or Professional Pager is 250-361-5958) OR SEND PATIENT TO THE EMERGENCY ROOM/CALL 911.

HIGH-RISK SYMPTOMS:

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

Assessments primarily for ADHD and Autism spectrum disorders not provided by this clinic.

REASON FOR REFERRAL

WHY IS PATIENT SEEKING MENTAL HEALTH AND/OR SUBSTANCE USE SERVICES?

SYMPTOM DETAILS, HISTORICAL CONTEXT, CURRENT STRESSORS:

LIST MHSU SERVICES CURRENTLY RECEIVING:

PREVIOUS MHSU SERVICE HISTORY: ☐ Within IH ☐ Elsewhere:_____

REFERRING PHYSICIAN SUSPECTED DIAGNOSIS:

TYPE OF MHSU SERVICE REQUESTED:

☐ Psychiatric Referral
☐ Single Session Therapy
☐ Mental Health Counselling
☐ Substance Use Counselling
☐ Detox (if seeking detox only please fax to Access Central – 250-519-1896)
☐ Other _____

MEDICATIONS:

Name	Date started	Amount	Frequency

Adverse reactions/allergies?

Problems affording medications?

SUBSTANCE USE:

Substance	Date last used	Amount	Frequency

Is there withdrawal/seizure risk due to use of alcohol and/or benzodiazepines?

Please attach all relevant EMRs, medication lists, consults, test results, and medical/psychiatry history and fax to Victoria CARES: 250-381-3222. If your client lives in the Western Communities fax to 250-370-5724.

Primary Care Providers can consult with a Mental Health & Substance Use triage clinician by calling Victoria CARES at 250-519-3485 or if your client lives in the Western Communities phone 250-370-5799

MHSU CLIENT QUESTIONNAIRE

TO BE FILLED OUT BY PATIENT OR CARE PROVIDER IF POSSIBLE

PLEASE PROVIDE AS MUCH INFORMATION AS YOU FEEL COMFORTABLE/SAFE SHARING

BACKGROUND INFORMATION FOR PSYCHIATRIC ASSESSEMENT
Patient Name:_____ **Date of Birth:**_____
What is your understanding of why you have been referred to psychiatric services by your family physician or nurse practitioner and what do you hope to get from an assessment:
Place of birth and where did you grow up:
Highest Level of education:
Source of Income:
Information about employment (type of work, hours, retired, etc.):
Relationship status (how long, concerns, etc.):
Housing (stable housing, own or rent, etc.):
Children (number and ages):
History of mental health or substance use services (when, how long, where, etc.):

Previous psychiatry/previous diagnosis (when, where, what, etc.):
Substance use, including alcohol, tobacco, cannabis, street drugs, misuse of over-the-counter medication, misuse of prescription medication (including how much, how often, route of injection, etc.):
Physical health concerns:
Previous or current legal issues:
History of trauma/abuse:
Family history of mental health or substance misuse concerns (diagnosed or suspected):