South Island Youth & Family Mental Health & Substance Use Referral

FAX REFERRAL FORM TO (250)519-5314 or PHONE (250)519-5313

Affix Patient Label Here

OUTCOME: *Connected to: Discovery* ☐ *YCC* ☐ *YSTAR* ☐ *YSURF* ☐ ***Intake Counselor:*** ***For internal use only***

Appointment Date/Time: ***Location:*** ***Counselor:***

Intake no service ☐ *referred to other community program* ☐ *Referral declined by client* ☐ *referral declined by MHSU* ☐

- **ENSURE REFERRAL IS COMPLETED IN ENTIRETY (2 PGS)**
- **A REFERRAL DOES NOT GUARANTEE ACCEPTANCE INTO MHSU PROGRAMS**
- **INTAKE WILL DETERMINE THE APPROPRIATE PROGRAM FOR YOUTH WITHIN PROGRAMS**

REFERRING AGENT INFORMATION: **DATE OF REFERRAL: _____**

REFERRED BY NAME/AGENCY:

_____

PHONE: _____ _____

EMAIL: _____

IDENTIFY CONTACT PERSON FOR REFERRAL:

_____

☐ Youth ☐ Parent ☐ Referral Agent

IS THIS REFERRAL FOR: ☐ YOUTH ☐ PARENTS/CAREGIVER ☐ FAMILY

If this is a parent referral, referral should be filled out with parent information, if this is a referral for a family, fill out referral with youth information and include parent/caregiver info in family member information section (2nd page)

CLIENT INFORMATION: GIVEN NAME: **PRONOUNS:**

Preferred Name:	**Age:**	**DOB:** **PHN#**
Address:		**Postal Code:**
School:		**Grade:**
Phone:		**Email:**
Preferred Contact: ☐ **Phone** ☐ **Text** ☐ **Email**		
Guardian/Caregiver:		**Contact number:**

Does the client identify as Indigenous? ☐ Yes ☐ No _____

Does the client identify with any other cultural identity? ☐ Yes ☐ No If yes, please specify:

REFERRAL INFORMATION:

WHAT MHSU PROGRAM IS THIS A REFERRAL FOR?

☐ **Discovery**
- Individual counselling
- Family/parent counselling
- Counselling for young people that are impacted by a family's substance use
- 13-19+ years

☐ **Youth Concurrent Disorder Clinician (YCC)**
- Individual Counselling
- Outreach
- Case Management
- 17-24 years

☐ **YSTAR**
- Case management
- Outreach
- Medical support/Harm reduction
- Systems navigation
- 12-24 years

☐ **YSURF**
- Hospitalization or presented to hospital due to suspected overdose
- No consent required for contact
- 13-18 years

Has client accessed any of the above programs in the past? ☐ **Yes** ☐ **No - If yes, program and when** _____

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REASON FOR REFERRAL:

REFERRAL ASSESSMENT: (check all that apply)

Substance use: ☐ Yes ☐ No
If yes, substances of concern:_____
_____
_____

Mental Health Diagnosis/concern: ☐ Yes ☐ No
If yes, concern/diagnosis: _____
_____
_____

Requires substance use medical care (i.e. withdrawal support, OAT) ☐ Yes ☐ No
If yes, specify: _____

Safety concerns: ☐ Yes ☐ No
If yes, concern: _____

Hospitalization or presented at hospital for overdose:
☐ Yes ☐ No If yes, date:_____

Housing concerns or unhoused: ☐ Yes ☐ No
If yes, specify: _____

In care of MCFD or Delegated Indigenous Agency:
☐ Yes ☐ No If Yes, specify: _____

Impacted by a family member's substance use: ☐ Yes ☐ No
If yes, relation of concern: _____

CLIENT CONSENT: (NOT REQUIRED FOR YSURF)

Client consent to referral: _____
Signature or verbal consent documented from referring services

Consent for Services to involve legal guardian: ☐ Yes ☐ No _____
Client signature or verbal consent documented from referring services

Client consents to exchange information between referral agent and MHSU Intake for the purpose of the referral
☐ Yes ☐ No

REFERRALS REQUIRE CLIENT CONSENT TO CONTACT AGENCIES/SUPPORT THAT THEY ARE ATTACHED TO FOR ADDITIONAL INFORMATION PERTAINING TO THE REFERRAL (E.G. CYMH, Youth Empowerment, MCFD, Foundry, school)

List relevant agencies or support that you are providing consent for intake/MHSU programs to contact if required:
_____
_____

Client consents to MHSU program contacting the listed agencies or supports: _____
Signature or verbal consent documented from referring services

FAMILY MEMBER INFORMATION: (When referral is for family support)

Name:	**DOB:**	**Relationship:**
PHN:	**Phone:**	
Name:	**DOB:**	**Relationship:**
PHN:	**Phone:**	

Questions? Email YouthMHSU.SouthIsland@islandhealth.ca