Office Use Only
Paris ID #: _____
Date Received: _____

Vancouver Coastal Health
Promoting wellness. Ensuring care.

qathet Mental Health & Substance Use Services
Central Intake: 604-485-3300 Fax: (604) 485-3303

REFERRAL FORM

Referred clients must reside within the Powell River catchment area

THIS IS NOT AN EMERGENCY SERVICE. **CALL 911 FOR EMERGENCY RESPONSE.**

Client Name: _____ **PHN:** _____
Last Name First Name Alias ***Does client have private insurance?*** ☐Yes☐No

Address: _____ DOB: _____ Gender: _____ **Pronoun:** _____

Primary Phone: _____ **Other Phone:** _____
Can message be left? ☐ Yes ☐ No *Can message be left? ☐ Yes ☐ No*

Primary Email Address: _____ **Is the client aware of this referral?** ☐ *Yes* ☐ *No* ☐ *N/A*

Preferred Language: _____ **Interpreter Needed?** ☐ *Yes* ☐ *No*

Who to Contact to Book Appointment if not client: Name (first/last): _____ Phone: _____

Emergency Contact (e.g., parent, Substitute Decision Maker): _____

Referring Source: *(name, agency, address, phone)*	**Primary Medical Care Provider:** *(e.g., family physician, nurse practitioner - name, address, phone, fax, MSP billing #)*

Referral Reason: Please refer to the descriptions and select only **one** of the following: *All referrals are screened within 3 business days and triaged accordingly for ongoing assessment and service provision. Clinicians will determine the applicability for community MHSU programming. Counselling referrals are for short term assessment and treatment; 6-10 sessions. If further care required, client will be referred on to other qGH MHSU services.*

☐ **Psychiatrist Consultation /Assessment request (GP/NP referred)**

☐ **Community MHSU Services**: Non urgent adult (19+) mental health and substance use.
- ☐ Primarily a mental health concern? ☐ Outpatient Clinical Counselling? ☐ Outpatient Concurrent D/O Counselling?
- ☐ Wellness Group (In-Person and Virtual) *Please call MHSU reception for information on additional groups available.

☐ **Older Adult Mental Health Team (OAMHT):** Non-urgent older adult (65+) cognitive decline with functional decline and/or mental health and substance use.

☐ **Youth:** Youth Substance Use referral (age 12-24)
- ☐ Concurrent Disorder Clinician (*ongoing counselling and case management for concurrent mental health and substance use*)
- ☐ Youth ICMT Nurse/Outreach (*Urgent request, Mental Health concern + Substance Use disorder, HBWM, Outreach*)

☐**Urgent Community MHSU Services – Priority Populations Teams**: Urgent request, Mental Health concern + Substance Use disorder, HBWM, Outreach
- ☐ Intensive Case Management (ICM) Team
- ☐ Overdose Outreach Team (OOT) – (SW, Outreach, Proactive Outreach Decriminalization)

☐ **WITHDRAWAL MANAGEMENT (DETOX)** - In Patient Medical Withdrawal Management with aftercare treatment options.

Presenting Problem: *(include symptoms, duration, severity, level of functioning and contributing factors; include other relevant information such as diagnoses, client on extended leave, ECT, impairments with cognition, sleep and mood if applicable) *If referral is for Depression, Anxiety, or Mood D/O please include PHQ9 and GAD assessment.*

If urgent, reason: _____

PLEASE COMPLETE PAGE 2 (RISK ISSUES, MEDICAL CONDITIONS, MEDICATIONS, ETC.; LAB WORK IF APPLICABLE) →

Note: If you have any additional collateral you would like to include (e.g., letters) please attach to this form when submitting.

Previous professional consultations, hospital admissions or ER visits: ☐ Yes *(attach reports)* ☐ No

SYMPTOMS: (Please check appropriate boxes, adding a clarifying comment to positive factors)

	N/A	MILD	MOD	SEVERE	Comments
Somatic Complaints					
Mood: Depressed					
Labile					
Manic					
Angry					
Dysregulated					
Anxiety or panic disorder					
Thought Disorder:					
Hallucinations					
Delusions					
Dementia					
Intellectually Challenged					
Relationship Issues					
Other (Specify in Comments section)					

Presenting Risk Factors:

IMPULSIVITY	☐	☐				
SUICIDALITY	☐	☐	☐ Thoughts/Ideation	☐ Stated Intent/Plan	☐ Previous Self-Harm	☐ Serious Attempts
VIOLENCE	☐	☐	☐ Verbal Threats	☐ Aggressive	☐ History of Assault	☐ Past/Present Charges
	☐	☐	Type _____		☐ Mild ☐ Moderate	☐

COMMENTS:

Risk of Harm to Others: ☐ Yes ☐ No
(e.g., homicidal ideation, escalating violence towards others such as biting/hitting/physical altercations, criminal or legal involvement, any risks to staff)
Describe:

Overdose Risk: ☐ Yes ☐ No ☐ N/A
Recent Overdose (30 days): ☐ Yes ☐ No **Date**: _____

Past Overdoses: ☐Yes ☐ No **If yes, How Many:** _____

Current Opioid Replacement Therapy: _____
OAT Prescriber: _____

Substance Use (if applicable): ☐ Not Applicable
Current **(C)** or Past **(P)**
Cocaine/Crack: ☐ *C* ☐*P* Alcohol: ☐ *C* ☐*P*
Benzodiazepines: ☐ *C* ☐*P* Nicotine: ☐ *C* ☐*P*
Hallucinogens: ☐ *C* ☐*P* Cannabis: ☐ *C* ☐*P*
Ecstasy/Club: ☐ *C* ☐*P* Stimulants/Crystal Meth: ☐ *C* ☐*P*

Other: _____

Describe *(e.g., type, frequency, amount, **what route**):*

Current Medications and Allergies (or attach MAR): **Please include Opioid replacement therapy **if applicable.***

If applicable, date of next injection medication: _____

Other Involved Supports: *(e.g., pediatrician, MCFD, other specialists, Home Health, PGT)*

Medical Conditions *(including allergies)* **and Other Risk Issues:** *(e.g., developmental delay, cognitive impairment, head injury, medically fragile, suspected abuse from others, overdose risk)*

Incomplete referral forms may be sent back to the referral source for completion.

By signing here, I acknowledge the ongoing nature of this collaborative approach to providing services for this client - -

Referring Partner Signature: _____ **Print Name**: _____

Contact information: _____ **Date:** _____ PRINT

Version 1 (27-Jan-2023)

PLEASE INCLUDE THE FOLLOWING DOCUMENTATION WITH REFERRAL IF PATIENT REFERRED FROM HOSPITAL:

- Hospital Face Sheet
- Current MAR
- Lab results
- Consults
- **ALL MENTAL HEALTH ACT FORMS INCLUDING FORM 4, 5, 6, 13, 15 AND 20.**

Please ensure you fill in EVERY section of referral form.

**Incomplete referral forms will be sent back for completion

Fax to 604-485-3303

Please contact **QATHET MHSU SERVICES at 604-485-3300** if you have any questions or concerns.