Intake Referral Form

PLEASE PRINT LEGIBLY - FAX all pages to 250-727-4441

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

Name: *last*_____ *first*_____ *Preferred name:* _____

Previous legal last name: _____ Gender: M ☐ F ☐ Other ☐ DOB (dd-mm-yyyy): _____

PHN: 9_____ MRN #: _____

Phone # *Primary*: _____ *Secondary*: _____ *Ok to leave messages?* _____

Address: _____

E-mail address (optional): _____

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

Date of Referral: _____ Referring Care Provider: _____ Name of referring Clinic: _____

Direct Phone Line: _____ Medical Professionals Line: _____ Fax: _____

Primary Care Physician (if different from referring physician): _____ MSP Number: _____

Is patient supportive of this referral? Y ☐ N ☐

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

HIGH-RISK SYMPTOMS - if any of the boxes are checked please provide details to the right

☐ 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
☐ Unstable/Lack of Housing
☐ 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

Please add details:

Click here to enter text.

Do you plan to remain MRP for Patients care: _____

Are you interested in Care Provider to Psychiatrist phone Consult in place or In person Patient assessment or to Facilitate care planning in advance of Patient Assessment?: (the need for Patient Assessment can be considered at the Time of Phone Consult) _____

What day of the week and time are you available: _____
_____

EPDS + GAD2

Patient is pregnant EDD; within 1 year PP; requires Preconception consultation

URGENCY

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

IF RISK REQUIRES AN IMMEDIATE RESPONSE, PLEASE REFER TO IMCRT (MOBILE CRISIS TEAM) via Confidential Pager for professionals only **250- 361-5958 after 1300 hours OR TO THE EMERGENCY ROOM, OR CALL 911.*

CURRENT STRESSORS

Click here to enter text.

REASON FOR REFERRAL

WHY IS THIS PATIENT SEEKING MENTAL HEALTH SERVICES?

Click here to enter text.

TYPE OF SERVICE REQUESTED: (Psychiatry, Single Sessions Therapy, Mental Health Counselling, Substance Use Counselling, Detox)

Click here to enter text.

MEDICATIONS

Name	Date started	Amount	Frequency
Click here to enter text.			

Adverse reactions/Allergies?

Click here to enter text.

Problems affording Medications?

Click here to enter text.

SUBSTANCE USE

Substance	Date last used	Amount	Frequency
Click here to enter text.			

Withdrawal/seizure risk?

Click here to enter text.

Please send along with all relevant EMRs, medication lists, consults, test results, and medical/psych history to 250-727-4441.