❑ P1 Child Unit Fax: 778-504-9765 ❑ P2 Adolescent Unit Fax: 778-504-9766

REFERRAL FOR BC CHILDREN'S HOSPITAL INPATIENT PSYCHIATRY UNITS

MANDATE

The Child and Youth Mental Health Program at Children's and Women's Health Centre of BC is a provincial resource providing mental health assessment, medication review, and short-term treatment, for BC and Yukon children, youth, and their families, ages 18 years and younger. Our primary mandate is to provide specialized consultation and care for children and youth with complex psychiatric concerns who have not responded to community treatment.

We are unable to provide assessments for insurance claims or medical-legal purposes, including custody.

Referral Criteria:

What is the age criteria?	**P1 Child Psychiatry Unit** 5-11 years old (or developmentally appropriate)	**P2 Adolescent Psychiatry Unit** 12-18 years old
Who can refer?	Referrals are usually made by a Child & Youth Mental Health Team psychiatrist and case manager. Private Psychiatrists, Pediatricians and Family Physicians may also refer and are encouraged to collaborate with their local Child & Youth Mental Health Team. We have a shared care model with the community team remaining involved. *Part of the BCCH psychiatry process for all inpatient referrals is for case managers to connect with available local Child or Adolescent Units in their region to see if they can meet the clinically indicated referral goals, and if needed, they'll redirect your referral to BCCH psychiatry.* *(Surrey APU, Kelowna APU, Prince George APAU, Ledger House - Child and Adolescent units.)*	
Is there a form that needs to be filled out?	Yes, please complete the Referral Form. http://www.bcchildrens.ca/mental-health-services-site/Documents/Inpatient%20Programs%20Referral%20Form.pdf	
How do you submit the referral form?	Completed community referral forms are to be reviewed and signed by local CYMH/Mental Health team leader/gatekeeper. Please contact the Nurse Clinician if you need your regional gatekeeper/team leader's contact information. All referral forms, with the most recent psychiatric assessment and any other relevant information (testing, assessments, etc.) are to be sent via fax.	
Description of target audience, in terms of their mental health challenge.	We serve children with a variety of challenges and diagnoses. These could include but are not limited to: Attention Deficit Disorder, Oppositional Defiant Disorder, Anxiety Disorders, Attachment Disorders, Obsessive Compulsive Disorder, Encopresis/Enuresis, Autism Spectrum Disorders, Depression, Mood Disorders, Schizophrenia, Psychosis, Learning Disabilities, Neurological Disorders, Trauma and Behaviour Challenges.	

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<table>
<tr><td rowspan="2">The consultation, admission, and post admission process</td><td colspan="2">We recognize that all family members are impacted by what happens to one member, therefore families/caregivers are an integral part of the care team. The family's/caregiver's involvement in the program is an opportunity to inform treatment, learn and develop new skills and gain an understanding of what is happening for their child.</td></tr>
<tr><td>P1 Child Psychiatry Unit
The admission is coordinated with the family and community team. An Outpatient or Video-conference Consultation will be scheduled in preparation for the admission. Admissions may have a virtual and brief in person component. The program runs from Monday morning to Friday afternoon, with overnight passes daily and extended weekend passes.

At the end of the admission, a discharge conference meeting will be scheduled and will include community agencies such as community physicians, school, and Child & Youth Mental Health. This is an opportunity to plan the child's transition back to community care.

The Child Psychiatry Program may provide some post-discharge support to help transition the child back to community partners in relation to the child's journey in the program.</td><td>P2 Adolescent Psychiatry Unit
Admission process:
Once referral received, the Adolescent Psychiatry Consultation Team reviews the referral. The consultation team meets with the family and community team either in person or via video conference to discuss what is happening for the youth and family and goals for the admission. Once admission is confirmed, the Nurse Clinician prepares youth and family for admission.

Post admission process:
Discharge planning will begin during admission. A discharge conference meeting will be held with a community agency such as Child and Youth Mental Health Team, community physician and school. This allows opportunity for youth/family to transition back to community.

The Adolescent Psychiatry Consultation Team will be available to support youth during transition to their community team if not available immediately following discharge.</td></tr>
<tr><td>Contact information</td><td colspan="2">If you have questions about the appropriateness of a referral or about the referral process, please call the nurse clinician. Incomplete referrals will be returned to the Community Case Manager for completion.

<table>
<tr><td>P1 Child Unit Nurse Clinician</td><td>604 875 2345 x 5608</td></tr>
<tr><td>P2 Adolescent Unit Nurse Clinician</td><td>604 875 2345 x 6939</td></tr>
<tr><td>P2 Adolescent Unit Youth and Family Counsellor</td><td>604 875 2345 x 5597</td></tr>
<tr><td>P1 Child Unit Fax</td><td>778-504-9765</td></tr>
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This form must be completed by a physician or clinician.

☐ Please tick here if consent (verbal) has been obtained from *ALL* legal guardians, the referring physician, and the community case manager.

Referral Date		**Case Manager** ❑ Agrees with referral		**Phone**	
		Email Address		**Fax**	

Name of Child/Youth		**DOB** (M/D/Y)	
Child's Address (inc. postal code)		**PHN**	

Living with	❑ Parents ❑ Foster Parents/Group Home ❑ Other: _____, grandparents/relative.			
Legal Status ❑ Legal guardian/caregivers agree with referral	❑ Parental Guardianship ❑ Custody: Joint/ Individual ❑ Parents Separated Joint/ Individual ❑ Temporary Ward ❑ Continuing Care Ward ❑ In Care by Agreement/VCA/SNA **Please include a copy of custody / guardianship papers**			
Social Worker (if applicable)		Email:	Phone:	Fax:
Parent's name		Email:	Cell:	Home:
Parent's name		Email:	Cell:	Home:
Caregiver (if not parents)		Email:	Cell:	Home:
Referring Doctor: ❑ Agrees with referral	Name:	**Interpreter Required?**	❑ Yes ❑ No Language: _____	
Seen by Psychiatrist?	❑ Yes ❑ No ❑ Not available. ❑ On waitlist (❑ local or ❑ outreach)	Last Seen: Next Appointment:		
	Name: Address: Email:	Phone: Fax:		
Seen by Pediatrician/GP?	❑ Yes ❑ No ❑ Not available. ❑ On waitlist (❑ local or ❑ outreach)	Last Seen: Next Appointment:		
	Name: Address: Email:	Phone: Fax:		
Child & Youth Mental Health Community Involvement?	❑ Yes ❑ No ❑ Not available ❑ On waitlist - estimated wait time:	Last Seen: Next Appointment:		
	Name: Address: Email:	Phone: Fax:		
MCFD/VACFSS/ Child Protection	Name: Phone:	Email:		
School Name & Grade		Phone: Email:		

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Most Recent DSM-V Diagnosis:

_____
_____
_____
_____

Reasons for Referral:

_____
_____
_____
_____
_____
_____
_____

Please specify current safety concerns:

Aggression Type: ☐ Verbal ☐ Physical to others ☐ Property damage ☐Other:_____ _____	☐ Self-Injury (e.g.: head bangs, scratches self) ☐ Suicidal ideation ☐ Suicide attempts ☐ Elopement/running away behavior ☐ Fire setting	☐ Sexualized behavior ☐ Theft ☐ Vandalism ☐ Other: _____ _____ _____

Current Medications: (Including dosage)	_____ _____ _____
Has there been a medication trial?	❑ No ❑ Yes _____ _____ _____

Please send the following information at time of referral:		
Psychiatrist Consults	❑ Yes ❑ No	If no, WHY?
CYMH Assessment	❑ Yes ❑ No	If no, WHY?
Child Protection Report	❑ Yes ❑ N/A	
Psycho-Ed Assessment	❑ Yes ❑ No	If no, WHY?
School Progress Note	❑ Yes ❑ No	If no, WHY?
School Individual Education Plan	❑ Yes ❑ No	If no, WHY?

CYMH/Mental Health Gatekeeper/ Team Leader	Name: Email:	**Signature:**