

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; with an exception made where we will see youth up to age 24 presenting with a co-occurring substance use issue.

Our primary mandate is to provide specialized consultation for children and youth with complex psychiatric concerns who have not responded to community treatment. In limited cases, we also provide consultation for children and youth with less complex concerns, in order to meet our multiple mandates of teaching, research, and program development.

If the referral does not fit the subspecialty mandate, the Compass Program will review the referral and provide you support based on the presented information. The community care provider can call Compass 1-855-702-7272 and get real time consultation support Monday through Friday 9-5pm.



WE ARE UNABLE TO PROVIDE AUTISM ASSESSMENTS, PSYCHOEDUCATIONAL ASSESSMENTS OR ASSESSMENTS FOR INSURANCE CLAIMS OR MEDICAL- LEGAL PURPOSES, INCLUDING CUSTODY.

PATIENT INFORMATION

Referral Date: _____ PHN: _____
 Child/Youth Surname: _____ First Name: _____
 Age: _____ DOB: _____ (MM/DD/YYYY) Gender: Male Female
 Address: _____
 _____ Postal Code: _____ Phone: _____
 Contact Person: _____ Relationship: _____
 Contact Person Phone: _____ Interpreter required: Yes No Language: _____

PARENT/GUARDIAN INFORMATION (please list all parents/guardians:

Name: _____ Relationship: _____ Phone: _____ Legal Guardian
 Name: _____ Relationship: _____ Phone: _____ Legal Guardian
 Child Resides with: _____
 Please tick here if **Consent** (verbal) has been obtained for **ALL** legal guardians

REFERRING DOCTOR INFORMATION:

Referring Physician: _____ Billing Number: _____
 GP Pediatrician Psychiatrist Other: _____
 Address: _____
 Phone: _____ Fax: _____

REFERRAL INFORMATION:

Has this patient seen any of the following:

Pediatrician	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psychiatrist in the last six months	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Community Child and Youth Mental Health Team	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please SPECIFY team: _____		
Psychologist or other counsellor	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcohol & Drug Counsellor	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Are there any CURRENT SAFETY CONCERNS? Please specify:

- Self-harm Suicide attempts Suicidal ideation
 CURRENT Aggression ***For aggression concerns please indicate:
Aggression Type:
 Verbal Property Physical to others To Self (e.g.: head bangs, scratches self) Other: _____

What is the REASON FOR REFERRAL?

- Diagnostic clarification Medication review Short term Treatment
 Group therapy 2nd opinion Metabolic concerns

What are the PSYCHIATRIC CONCERNS?

- Anxiety Depression Learning difficulties Anger/oppositional behavior
 Sleep problems Inattention Obsessions/compulsions Peer relationship difficulties
 Hallucinations Delusions School difficulties Family relationship difficulties
 Hyperactivity Developmental Delay
 Substance use: _____

Autism * Please note we do not provide autism assessments, but do see children with previously diagnosed autism and emotional/behavioral concerns*

PLEASE PROVIDE DETAILS ON THE SEVERITY OF THE PSYCHIATRIC CONCERNS AND THE EFFECT ON THE PATIENT'S FUNCTIONING (Please attach copies of relevant reports).

RELEVANT MEDICAL HISTORY & CURRENT MEDICATIONS (including dosage):

Please forward the most recent patient information with your referral (if available): Height, Weight, BMI, Growth Chart, Vitals, Laboratory Test Results

For general information on mental health issues and community resources visit the Kelty Mental Health Resource Centre at www.keltymentalhealth.ca or 604-875-2084

To access immediate physician phone support about a patient, contact the Compass Program:
1-855-702-7272

PLEASE READ THE FOLLOWING REGARDING OUR NEW REFERRAL FORM

Thank you for your recent referral to the Child and Youth Mental Health Program at Children's and Women's Health Centre of BC. As part of our program development we have recently undertaken a *Rapid Process Improve Workshop* to develop a new referral form in order to enhance our intake process.

Please fill out both sides of the referral form as well as attaching relevant documentation to support the referral and fax to 604.875.2099 upon completion.

If your office currently is in possession of our old referral form, please remove the old form and replace it with our new one.

If you have any questions regarding the new form, please contact our intake team at 604.875.2010.