PROVINCIAL MENTAL HEALTH METABOLIC PROGRAM

REFERRAL INTAKE FORM Phone: 604-875-2345 ext 5592 Date:_____

Thank you for your referral to the Mental Health Metabolic Program

Patient Name:

DOB: PHN:

Phone: Email:

☐ Any other involved caregivers that should be present at appt:

☐ Does an interpreter need to be booked? Language:

☐ Please tick here if consent for referral has been obtained from all legal guardians

Referring Physician:

Phone: Fax:

Please provide the following information (as available) or dictated letter specifying:

☐ Reason for referral:

☐ elevated blood sugars ☐ elevated cholesterol

☐ elevated prolactin ☐ obesity/accelerated wt gain ☐ other metabolic concerns:

☐ Growth chart (plotted with percentiles)

☐ Lab results (including baseline monitoring):

☐ Current medications (including dose and date began):

☐ Brief Psychiatric History (please attach most recent psychiatric note):

☐ Safety Concerns:

☐ Substance Use Concerns:

Please fax the requested information to: **(604)875-2271**

☐ We are unable to prioritize your referral OR book an appointment until ALL missing information (noted above) is received

Your referral has been accepted. Your patient can expect to be seen in:

☐ <4 weeks ☐ <8 weeks ☐ <3 months ☐ <6 months

While your patient is on our waitlist, have the following labs done:

Your referral has been declined for the following reason(s):

Date Triaged: