❑ Child Unit ❑ Adolescent Unit

REFERRAL FOR BC CHILDREN'S HOSPITAL INPATIENT PSYCHIATRY UNITS

Referral Date		**Case Manager**		**Phone**	
Address		**Email address**		**Fax**	
Name of Child/Youth			**DOB** (y/m/d)		
Address			**PHN**		
Living with	❑ Parents ❑ Foster Parents/Group Home				
Legal Status	❑ Parental Guardianship ❑ Custody: Joint/ Individual ❑ Parents Separated Joint/ Individual ❑ Temporary Ward ❑ Continuing Care Ward ❑ In Care By Agreement **Please include a copy of custody / guardianship papers**				
Parents' Names	Mother:		Father:		
	E-Mail:		E-Mail:		
	Home Ph.: Cell:		Home Ph.: Cell :		
Caregiver (if not parents)	Name: Email:				
Referring Doctor:			**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		Last Seen: Next Appointment:		
	Name: Address: Email:		Phone: Fax:		
Assessed by Mental Health?	❑ 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			Phone:		

Most Recent DSM-V Diagnosis:

Reasons for Referral:

Has there been a medication trial?	❑ No ❑ Yes name:

ESSENTIAL Information to be provided 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	
School Progress Note	❑ Yes ❑ No	If no, WHY?
Individual Education Plan	❑ Yes ❑ N/A	

MH Gatekeeper	**Name:** **Email:**	**Signature:**

Incomplete referrals will not be processed and will be returned to the Community Case Manager for completion. Fax completed form to 604 875 2099.