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 ☐ metabolic monitoring ☐ 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) 875-2099

☐ 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:
☐ <3 weeks ☐ <6 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):