BC MENTAL HEALTH
& SUBSTANCE USE SERVICES
An agency of the Provincial Health Services Authority

Physician Referral Form

Provincial Mental Health Metabolic Program

Part 1: Physician Information		
Referring physician:		**Billing number:**
Phone:	**Fax:**	**Email:**
Address:		
Other involved physician:		**Billing number:**

Part 2: Patient Information		
Surname:	**First Name:**	
Gender: ☐ Male ☐ Female	**DOB:** Day/Month/Year	**Age:**
Personal Health Number:	**Email:**	
Address:		
Day Phone:	**Cell Phone:**	**Other:**

Part 3: Parent and Legal Guardian Information		
Please list all parents and/or legal guardians.		
Surname:	**First Name:**	
Relationship:	**Phone:**	☐ **Legal Guardian**
Surname:	**First Name:**	
Relationship:	**Phone:**	☐ **Legal Guardian**

Part 4: Consent	
*****It is essential that consent is obtained from the patient, parent and/or legal guardian prior to referral.*****	
☐ Please tick here if consent has been obtained from <u>all</u> legal guardians.	
Who should we contact to book the appointment?	
Name:	**Contact Phone Number:**
Relationship to Patient:	

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Part 5: Reason for Referral (please comment in all sections)
Reason for referral: (e.g. school, family, social difficulties, medication consult, metabolic concerns)
Brief history of psychiatric concerns: (list concerns, how long, past/present professionals involved)
All signs and symptoms of psychiatric difficulties: (e.g. sleep, appetite, mood difficulties)
Safety concerns including past or present risk of harm to self or others:
Substance use concerns including past of present alcohol use and/or drug use:

Part 6: Medical Information
Relevant investigations and completed results:
Current medications: (including dose and date began)
Allergies:
Known medical conditions and risk factors: (e.g. family history, use of SGAs)

Please fax completed form, all relevant consultation reports, and any additional information to 604-875-2099.