Adolescent Health Clinic
V2-203 Clinical Support Building
950 West 28th Avenue
Vancouver, BC V5Z 4H4
Phone: 604-875-3472
Fax: 604-875-3958

Adolescent Health Clinic Referral Form

Helpful information about the clinic: The team consist of a group of adolescent medicine pediatricians and a nurse. Patients **12-18 years** are seen for **non-urgent** services. The team can help provide consultation and recommendations using a **holistic, youth-centred** approach. This clinic does not have psychiatry, counselling, psychotherapy, social work, physiotherapy, or dietician services.

We only accept referrals from pediatricians, pediatric subspecialty NP's, and psychiatrists. If you are a primary care provider, please consider referring your patient to a general pediatrician first.

We do not accept referrals for isolated mental health or substance use without a chronic health condition (consider consulting with BC Children's Hospital Compass Team https://compassbc.ca), sexual health issues alone, primary eating disorders (please refer to regional secondary eating disorder services), or for emergency and/or crisis situations.

For more information, please see: http://www.bcchildrens.ca/our-services/clinics/adolescent-health

Patient Information

Last name: _____ First name: _____

Preferred name: _____

Gender: __female____ ____ Sex assigned at birth__female____ __ Pronouns__she/her_____

DOB: _____ PHN:_____ MRN:_____

Address: _____

Parent/guardian name: _____

Parent/guardian phone number: _____

Interpreter Required: ☐Yes ☐No Language: _____

Is this a referral for ☐ Adolescent Health Clinic ☐ Mindfulness Awareness and Resiliency Skills for Adolescents (MARS-A) only ☐Both

Is the patient aware and agreeable to this referral? ☐Yes ☐No

Are Parents/ Guardians aware of this referral? ☐Yes ☐No

Who should be contacted to book the appointment?

☐**Patient Only**: Phone number:_____ ☐Ok to leave a message

☐Parent/Guardians ☐Ok to leave a message

Referring Provider Information

Referring Provider: _____ Designation/ Dept: _____

Phone: _____ Fax: _____ Referral Date: 1/25/24

*Please complete referral information on the next page. Thank you for the referral. Incomplete referrals will be returned for completion.

*Our clinic will contact the patient/family directly with appointment information

Eligibility criteria and referral information. Please check all that apply:

☐ Chronic health condition(s) (please list): _____

_____

AND (at least one of the following):

☐ Mental Health Concerns (please describe): _____

_____

_____

☐ Significant risk taking behaviours (please describe): _____

_____

_____

☐ Functional Impairment (check all that apply) ☐ School ☐ Home/family ☐ Peers ☐ Activities of Daily Living

Please explain: _____

_____

☐ Somatic symptoms (please list): _____

_____

_____

☐ Complex sexual health concerns that cannot be dealt with in primary care and/or a local Sexual Health Youth Clinic: _____

☐ Complex patient needing support regarding transition to adult health care (describe how you think Adolescent Medicine can support this): _____

_____

_____

Other helpful information (attach additional sheets or documents as needed): _____

_____

_____

Please list those already involved. Please include when a referral has been made and services are pending:

Care Provider	Name and/or Location	Phone Number
Primary Care Provider		
Foundry		
Regional Eating Disorders Team		
Mental Health Team (CYMH, other)		
Counsellor/Therapist, School Counsellor		
Psychiatrist		
Social Worker (MCFD, CYSN, Delegated Aboriginal Agency, etc.)		
Indigenous Support		
Youth Worker, Outreach Worker, Youth-serving agency, etc.		