BC CHILDREN'S HOSPITAL
An agency of the Provincial Health Services Authority

□ Child Unit □ Adolescent Unit

REFERRAL FOR BC CHILDREN'S HOSPITAL INPATIENT CHILD PSYCHIATRY UNIT

Referral Date		**Case Manager**		**Phone**	
Address		**Email address**		**Fax**	
Name of Child/Youth			**DOB** (y/m/d)		
Address (inc. postcode)			**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	Parent 1:	Parent 2:
	E-Mail:	E-Mail:
	Home Ph.: Cell:	Home Ph.: Cell :
Caregiver (if not parents)	Name: Email:	Phone : Cell:
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 ❑ Not available ❑ On waitlist (❑ local or ❑ outreach)	Last Seen: Next Appointment:
	Name: Address: Email:	Phone: Fax:
Child & Youth Mental Health Community Involvement?	❑ 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 & Grade		Phone:

Most Recent DSM-V Diagnosis:

Reasons for Referral:

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

Please send the following information 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 ❑ No	

Mental Health Gatekeeper/ Team Leader	**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.