Child and Adolescent Mental Health Outpatient Programs Referral Form

Fax: 604-875-2099
Do you have a question?: Compass Program 1-855-702-7272

MANDATE

The Child and Youth Mental Health Program at Children's and Women's Health Centre of BC is a provincial resource providing mental health assessment, medication review, and short term treatment, for BC and Yukon children, youth, and their families, ages 18 years and younger; with an exception made where we will see youth up to age 24 presenting with a co-occurring substance use issue.

Our primary mandate is to provide specialized consultation for children and youth with complex psychiatric concerns who have not responded to community treatment. In limited cases, we also provide consultation for children and youth with less complex concerns, in order to meet our multiple mandates of teaching, research, and program development.

If the referral does not fit the subspecialty mandate, the Compass Program will review the referral and provide you support based on the presented information. The community care provider can call Compass 1-855-702-7272 and get real time consultation support Monday through Friday 9-5pm.

WE ARE UNABLE TO PROVIDE AUTISM ASSESSMENTS, PSYCHOEDUCATIONAL ASSESSESSMENTS OR ASSESSMENTS FOR INSURANCE CLAIMS OR MEDICAL- LEGAL PURPOSES, INCLUDING CUSTODY.

PATIENT INFORMATION

Referral Date: _____ PHN:_____

Child/Youth Surname:_____ First Name:_____

Age: _____ DOB:_____ (MM/DD/YYYY) Gender: ☐Male ☐ Female

Address: _____

_____ Postal Code:_____ Phone: _____

Contact Person:_____ Relationship:_____

Contact Person Phone:_____ Interpreter required: ☐Yes ☐No Language: _____

PARENT/GUARDIAN INFORMATION(please list all parents/guardians:

Name: _____ Relationship: _____ Phone: _____ ☐ Legal Guardian

Name: _____ Relationship: _____ Phone: _____ ☐ Legal Guardian

Child Resides with: _____

☐ Please tick here if **Consent** (verbal) has been obtained for ***ALL*** legal guardians

REFERRING DOCTOR INFORMATION:

Referring Physician: _____ Billing Number: _____

☐ GP ☐Pediatrician ☐ Psychiatrist ☐Other: _____

Address:_____

Phone: _____ Fax: _____

REFERRAL INFORMATION:

Has this patient seen any of the following:

Pediatrician	☐ Yes	☐ No
Psychiatrist in the last six months	☐ Yes	☐ No
Community Child and Youth Mental Health Team	☐ Yes	☐ No
If yes, please SPECIFY team: _____		
Psychologist or other counsellor	☐ Yes	☐ No
Alcohol & Drug Counsellor	☐ Yes	☐ No

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Are there any CURRENT SAFETY CONCERNS? Please specify:

☐ Self-harm ☐ Suicide attempts ☐ Suicidal ideation

☐ **CURRENT** Aggression ***For aggression concerns please indicate:**

Aggression Type:

☐ Verbal ☐ Property ☐ Physical to others ☐ To Self (e.g.: head bangs, scratches self) ☐ Other: _____

What is the REASON FOR REFERRAL?

☐ Diagnostic clarification ☐ Medication review ☐ Short term Treatment
☐ Group therapy ☐ 2nd opinion ☐ Metabolic concerns

What are the PSYCHIATRIC CONCERNS?

☐ Anxiety ☐ Depression ☐ Learning difficulties ☐ Anger/oppositional behavior
☐ Sleep problems ☐ Inattention ☐ Obsessions/compulsions ☐ Peer relationship difficulties
☐ Hallucinations ☐ Delusions ☐ School difficulties ☐ Family relationship difficulties
☐ Hyperactivity ☐ Developmental Delay
☐ Substance use: _____ ☐

Autism * Please note we do not provide autism assessments, but do see children with previously diagnosed autism and emotional/behavioral concerns.

PLEASE PROVIDE DETAILS ON THE SEVERITY OF THE PSYCHIATRIC CONCERNS AND THE EFFECT ON THE PATIENT'S FUNCTIONING **(Please attach copies of relevant reports)**.

_____
_____
_____
_____
_____

RELEVANT MEDICAL HISTORY & CURRENT MEDICATIONS (**including dosage*****):***

_____
_____
_____
_____
_____

For general information on mental health issues and community resources visit the Kelty Mental Health Resource Centre at www.keltymentalhealth.ca or 604-875-2084

To access immediate physician phone support about a patient, contact the Compass Program: 1-855-702-7272

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PLEASE READ THE FOLLOWING REGARDING OUR NEW REFERRAL FORM

Thank you for your recent referral to the Child and Youth Mental Health Program at Children's and Women's Health Centre of BC. As part of our program development we have recently undertaken a *Rapid Process Improve Workshop* to develop a new referral form in order to enhance our intake process.

Please fill out both sides of the referral form as well as attaching relevant documentation to support the referral and fax to 604.875.2099 upon completion.

If your office currently is in possession of our old referral form, please remove the old form and replace it with our new one.

If you have any questions regarding the new form, please contact our intake team at 604.875.2010.