island health

Child and Adolescent Psychiatry Program (CICAPP)
Child Youth and Family Mental Health (CYFMH)

Intake Referral Form

MANDATE

- The primary mandate of Child and Adolescent Psychiatry Program (CICAPP) is to provide tertiary services to children, youth and their families throughout Central Vancouver Island within the catchment area that lies between Ladysmith, Bowser and Port Alberni.
- In most cases it is expected that mental health assessment and treatment has been initiated and referrals are made due to a need for a more specialized psychiatric assessment.
- The ongoing involvement of community physicians and mental health professionals is essential to support the continuing needs of these clients. Our goal is to communicate with families and involved professionals throughout our process of assessment and we encourage you to contact us.

REFERRAL PROCESS

1. **Complete the two page form (please print clearly) and fax to 250-755-7946. The consent should be signed by the legal guardian and/or child 12 years and older before the referral will be considered.**
2. If you wish to discuss the referral before submitting, phone Intake at 250-755-7945.
3. Additional documentation in regard to program admission criteria may be requested. Relevant reports and assessment documents must be faxed to CICAPP Intake at: 250-755-7946. **Eligibility criteria** exist for CICAPP.
4. **Completion of this form does not guarantee service.**

Patient Information:

Full Legal Name:		
Preferred Name:		DOB:
Current Address:		
City:	Province:	Postal Code:
Gender: ☐ Prefer not to disclose	Phone:	Cellular:
Family Physician:		Last Physical Exam:
Provincial Health Number:	School:	Phone:

Parent/Guardian Information:

Legal Guardian Name:		
Current Address:		Relationship:
City:	Province:	Postal Code:
Phone:	Child resides with:	Relationship:

Consent:

I _____(Legal Guardian) and _____(Child/Youth 12 years and older) give consent for CYFMH / CICAPP employees to receive and share information related to the mental health assessment and treatment needs of: _____ with other professionals in order to facilitate the provision of continuing care.

Signature of Legal Guardian:_____ Date:_____
Signature of Child:_____ Date:_____
Signature of Witness:_____ Date:_____

Referring Physician:

Referring Physician:		Billing Number:
Current Address:		
City:	Province:	Postal Code:
Phone:	Fax:	

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MEDICAL DIAGNOSIS / RELEVANT MEDICAL HISTORY & CURRENT MEDICATIONS (include dosage):

ARE THERE ANY CURRENT SAFETY CONCERNS? Please specify:

☐ Self-harm ☐Suicidal ideation ☐ Aggression ☐Suicide Attempts

What is the reason for this referral: (Please specify or attach a separate sheet if necessary.)

Has this patient been referred to any other programs? If yes, please specify:

Other Involved Professionals:

☐ Pediatrician:
☐ Psychiatrist:
☐ Psychologist:
☐ Counsellor:
☐ Community Mental Health Team:
☐ Are there any other professionals involved? (if yes, please specify):

What are the presenting concerns? (Please check all that apply)

☐ Anger/Oppositional Behaviour	☐ Hallucinations/Delusions	☐ Peer Relationship Difficulties
☐ Anxiety	☐ Hyperactivity	☐ School Difficulties
☐ Behaviour/Dysregulation	☐ Inattention	☐ Sleep Problems
☐ Depression/Mood	☐ Learning Difficulties	☐ Substance Abuse
☐ Developmental Delay	☐ Obsessions/Compulsions	☐ Other:_____

Please provide details on severity of the psychiatric concern and the effect on the patient's functioning (please attach copies of relevant reports):

How can we best meet this client's cultural and/or spiritual needs?

Please indicate who will be following up with this patient after tertiary level service is completed:

1. Prescribing Physician (if indicated):_____
2. Community Clinician/Case Manager:_____