



# Intake Referral Form

**Service requested by Child/Youth, Family & Community:**

- Inpatient   
  Outpatient   
  Parent Connect (for CYFMHS use only)

**MANDATE**

- The primary mandate of Child, Youth & Family Mental Health Services is to provide tertiary services to children, youth and their families throughout Vancouver Island and the Gulf Islands.
- In most cases it is expected that mental health assessment and treatment has been initiated in the home community and referrals are made due to a need for more intensive multidisciplinary assessment and/or treatment on an inpatient or an outpatient basis.
- 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 treatment and we encourage you to contact us.

**REFERRAL PROCESS**

1. **Complete two-page form (please print) and fax to (250) 519-6789. The Consent must be signed by the legal guardian and child 12 years and older before the referral will be considered.**
2. If you wish to discuss the referral before submitting, phone Intake (250) 519-6720 or (250) 519-6794 or Ledger Reception (250) 519-6908.
3. Additional documentation in regard to program admission criteria may be requested. Relevant reports and assessment documents must be faxed to CYFMHS Intake (250) 519-6789. **Eligibility criteria** exist for all programs.
4. Please make requests for **urgent** inpatient admissions directly by phoning (250) 519-6720 or (250) 519-6794.

Patient Information:			
Full Legal Name:			
Preferred Name:			DOB:
Current address:			
City:	Province:	Postal Code:	
Gender: <input type="checkbox"/> Prefer not to disclose	Phone:	Cellular:	
Family Physician:		Last Physical Exam:	
PHN:	School:	Phone:	
Parent/Guardian Information:			
Legal Guardian Name:			
Current address:			Relationship:
City:	Province:	Postal code:	
Phone:	Child resides with:	Relationship:	

*This form can be completed by a physician or mental health clinician only; completion of this form does not guarantee service*



# Intake Referral Form

<b>Consent</b>		
I _____ (Legal Guardian) and _____ (Child/Youth 12 years and older)		
Give consent for CYFMHS 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: _____
<b>Referring Physician or Mental Health Clinician Information:</b>		
Referring physician/MH Clinician name: _____		
Billing number: _____		
Current address: _____		
City: _____	Province: _____	Postal Code: _____
Phone: _____	Fax: _____	
Has this patient been referred to any other programs? If yes please specify: _____		
What is the reason for this referral: Please specify: _____		
<input type="checkbox"/> Diagnostic clarification		<input type="checkbox"/> Medication review
<input type="checkbox"/> Multidisciplinary assessment <input type="checkbox"/> Psych <input type="checkbox"/> OT <input type="checkbox"/> Speech & Language		<input type="checkbox"/> Community/School consultation
<b>Outpatient only:</b> <input type="checkbox"/> Family work/support <input type="checkbox"/> Individual/Family treatment		<b>Special Care Unit only:</b> <input type="checkbox"/> Stabilization
<b>ARE THERE ANY CURRENT SAFETY CONCERNS? Please specify:</b>		
<input type="checkbox"/> Self-harm	<input type="checkbox"/> Suicidal ideation	<input type="checkbox"/> Aggression
<b>Referral Information:</b>		
Has this patient seen any of the following? (if yes please specify name and contact information):		
<input type="checkbox"/> Pediatrician:		
<input type="checkbox"/> Psychiatrist:		
<input type="checkbox"/> Psychologist:		
<input type="checkbox"/> Counsellor:		
<input type="checkbox"/> Community Mental Health Team:		
<input type="checkbox"/> Are there any other professionals involved? (if yes, please specify): _____		

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<b>What are the PSYCHIATRIC CONCERNS? (Please check all that apply)</b>		
<input type="checkbox"/> Anger/Oppositional behaviour	<input type="checkbox"/> Hallucinations/Delusions	<input type="checkbox"/> Peer Relationship Difficulties
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> School Difficulties
<input type="checkbox"/> Behaviour/Disregulation	<input type="checkbox"/> Inattention	<input type="checkbox"/> Sleep Problems
<input type="checkbox"/> Depression/Mood	<input type="checkbox"/> Learning Difficulties	<input type="checkbox"/> Substance Use
<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Obsessions/Compulsions	<input type="checkbox"/> Other (please describe)
<b>PLEASE PROVIDE DETAILS ON SEVERITY OF THE PSYCHIATRIC CONCERNS AND THE EFFECT ON THE PATIENTS FUNCTIONING (please attach copies of relevant reports):</b>		
<b>DIAGNOSIS/RELEVANT MEDICAL HISTORY &amp; CURRENT MEDICATIONS (including dosage):</b>		
<b>How can we best meet this client's cultural and/or spiritual needs?</b>		
<b>Please indicate who will be following up with this patient after tertiary level service is completed:</b>		
<b>1. Prescribing Physician (if indicated):</b> _____  <b>2. Community Clinician/Case Manager:</b> _____		