Developmental Disability Mental Health Team
Mental Health and Substance Use
203-3939 Quadra Street Victoria, BC V8X 1J5
Phone 250-519-3519 Fax 250-519-3518
www.viha.ca/mhas

Medical Referral for DDMHT Psychiatric Assessment

Date of Referral: ___________________

Client Name: DoB: PHN:

Referral question/reason(s):

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Please check all that are relevant:

☐ Suicidal ☐ Homicidal ☐ Violent/Aggressive ☐ Child Abuse ☐ Substance misuse
☐ Allergy Alert ☐ Serious medical condition ☐ Other concerns (Please list below)

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CURRENT SYMPTOMS

☐ Changes in Sleep
☐ Changes in appetite
☐ Changes in concentration
☐ Changes in energy
☐ Hallucinations/delusions
☐ Drug/alcohol misuse
☐ Functional decline
☐ Other
☐ Self–injurious behaviour
☐ Medication side-effects
☐ Aggression

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Date of last office visit:_______________

Height:______________ Weight:_____________ BP__________ Waist Circumference:_______________

Date Information taken: _____________

Please list current Medications (or attach list)

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Provider Signature:_______________________________ MSP Billing#: _______________

Please Print Provider name: ______________________________