



**Request for Medical Referral for Psychiatric Appointment to  
DDMHT Child & Youth Consultation Service**

Dear Provider,

DDMHT Child and Youth Consultation Service is a collaborative service, designed to provide one-time psychiatric assessment of children & youth age 5 – 19 with special needs (ASD, FASD, CP etc) that currently do not have access to or do not meet eligibility requirements for DDMHT, VIHA Child and Adolescent psychiatry services, or MCFD/ CYMH services.

The patient being to this service will be seen by our Child and Adolescent Psychiatrist, Dr. Gisele Ferguson, MSP 66448.  
As the primary care provider, you must be in favour of the Consultation to proceed.

If you support this consultation, please complete and return this Psychiatric Assessment Referral form with any supporting documentation to us by mail at the above address, or by **fax at 250-519-3518**

Patient NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

PHN: \_\_\_\_\_

- Date last seen by Primary Care Provider \_\_\_\_\_
- Height \_\_\_\_\_ Wt. \_\_\_\_\_ BP \_\_\_\_\_ Waist Circumference \_\_\_\_\_
- Date above information taken \_\_\_\_\_
- Please state your referral question:

Please also include:

- Copy of current medications including when started and PRNs and side effects
- Any Allergies
- Copies of any laboratory test results, medication changes and specialist's reports.

Provider Signature \_\_\_\_\_ MSP Billing # \_\_\_\_\_ Date \_\_\_\_\_

Print Provider name: \_\_\_\_\_

**The direct medical care and prescribing will remain in the hands of the family physician, nurse practitioner or paediatrician.**

You will be supplied with a copy of the reports and recommendations that follow from this review.

**ACTION REQUIRED – PROVIDER PLEASE SIGN AND SEND  
TO DDMHT WITH SUPPORTING DOCUMENTATION**