



MENTAL HEALTH & SUBSTANCE USE INTAKE REFERRAL FORM (FOR PATIENTS 19+)

Fax ATTN: MHSU Clinicians
1-250-538-4877

PLEASE PRINT LEGIBLY PATIENT INFORMATION

Name: last first alias?: Gender: M F Other
DOB (dd-mm-yyyy): PHN: 9 Address:
MRN #: Phone # Home: Work/Other:

REFERRAL INFORMATION

Date of Referral: Source of Referral:
Primary Care Provider: Phone: Private Line: Fax:
Date of last physical exam: Is patient supportive of this referral? Y N

REASON FOR REFERRAL

WHY IS THIS PATIENT SEEKING MENTAL HEALTH OR ADDICTION SERVICES?

CURRENT CLINICAL FEATURES - Please check all that apply:

Risk Factors:

- Risk of harm to others plan? means available
Risk of harm to self plan? means available
Suicide attempt history method
Recent actions taken to a suicide/homicide plan
Behaviour influenced by delusions/hallucinations
Patient is experiencing command hallucinations
Pronounced Self Neglect
Serious complicating medical problem?

- Pronounced and/or Resistant Depression
Psychotic Symptoms
Manic/Hypomanic Symptoms
Major Cognitive Impairment/Disorganization
Unstable/Lack of Housing
Other:
Chronic Emotional/Behavioural Instability
Generalized Anxiety
Panic Attacks
Social Phobia
Obsessive/Compulsive Behaviours
Other:

Please describe any risk factors identified:

Significant Drug/Alcohol Abuse? (Please mark below)

Table with 4 columns: Substance, Typical Method, Quantity, Frequency. Rows 1-4.

Previous/Current Treatments: (Including psychiatric admissions & addictions services)

Table with 3 columns: Type, Dose, Date. Rows 1-4.

Medical History and Investigations: (Please attach investigation results)

Table with 1 column for notes. Rows 1-4.

* IF PATIENT'S RISK REQUIRES A RESPONSE TODAY, PLEASE REFER TO IMCRT (MOBILE CRISIS TEAM 361-5958 after 1300 hrs Confidential Pager for professionals only) OR TO THE EMERGENCY ROOM, OR CALL 911.

PLEASE DESCRIBE CURRENT SYMPTOMS AND ANY COMPLICATING FACTORS:

CURRENT MEDICATIONS:

(Attach printout of current symptoms/medications from GP Chart if preferred)

Table with 3 columns: Type, Dose, When Initiated. Rows 1-6. Includes questions about adverse reactions and allergies.

TO BE COMPLETED BY MHAS ADMINISTRATIVE STAFF:

- Systems Checked: CERNER, MH Intake Tracking System, PM Office, MHDB, Powerchart reviewed by clinician

TO BE COMPLETED BY INTAKE STAFF:

Message Log:

Table with 4 columns: To Whom, When, M/L, Staff Signature.

Please fax this form and the completed Patient Questionnaire to:

FAX: 1-250-538-4877
Lancer Building
PHONE: 1-250-538-4711

#202-323 Lower Ganges Road, Salt Spring Island, BC V8K 2V4