



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

PLEASE PRINT LEGIBLY - FAX all pages to 250-381-3222

PATIENT INFORMATION – if this information is not completed the referral will not be processed

Name: *last* _____ *first* _____ *Preferred name:* _____

Gender: M F Other DOB (dd-mm-yyyy): _____

PHN: 9 _____ MRN #: _____

Phone # *Primary:* _____ *Secondary:* _____ *Ok to leave messages?* _____

Address: _____

E-mail address (optional): _____

REFERRAL INFORMATION – if this information is not completed the referral will not be processed

Date of Referral: _____ Referring Physician: _____ Name of referring Clinic: _____

Clinic Phone: _____ Medical Professionals Line: _____ Fax: _____

Primary Care Physician (if different from referring physician): _____

Is patient supportive of this referral? Y N

Would patient like to receive service in the WestShore? (MHSU West Shore service is for mild/moderate needs only) Y N

If the patient is referred to CBT Skills Group are you willing to remain MRP? Y N

CURRENT CLINICAL FEATURES - Please check all that apply, then provide any additional information:

HIGH-RISK SYMPTOMS - if any of the boxes are checked please provide details to the right

Risk of harm: to self others plan?

Suicide / homicide risk assessment completed by referring physician?

Psychotic Symptoms

Behaviour influenced by delusions/hallucinations

Patient is experiencing command hallucinations

Substance Use – increased and/or excessive

Falls/mobility risks

Child protection concerns; MCFD contacted? _____

SYMPTOMS

Pronounced and/or Resistant Depression

Manic/Hypomanic Symptoms

Major Cognitive Impairment/Disorganization

Unstable/Lack of Housing

Suicide attempt history

Chronic Emotional/Behavioural Instability

Generalized Anxiety

Panic Attacks

Social Phobia

Obsessive/Compulsive Behaviour

Please add details:
Click here to enter text.

URGENCY

Semi-Urgent / Moderate

Non-Urgent / Routine

**IF RISK REQUIRES AN IMMEDIATE RESPONSE, PLEASE REFER TO IMCRT (MOBILE CRISIS TEAM) via Confidential Pager for professionals only 250- 361-5958 after 1300 hours OR TO THE EMERGENCY ROOM, OR CALL 911.*

CURRENT STRESSORS

[Click here to enter text.](#)

REASON FOR REFERRAL

WHY IS THIS PATIENT SEEKING MENTAL HEALTH OR SUBSTANCE USE SERVICES?

[Click here to enter text.](#)

TYPE OF SERVICE REQUESTED: (Psychiatry, Single Sessions Therapy, Mental Health Counselling, Substance Use Counselling, Detox)

[Click here to enter text.](#)

MEDICATIONS

Name	Date started	Amount	Frequency
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[Click here to enter text.](#)

Adverse reactions/Allergies?

[Click here to enter text.](#)

Problems affording Medications?

[Click here to enter text.](#)

SUBSTANCE USE

Substance	Date last used	Amount	Frequency
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[Click here to enter text.](#)

Withdrawal/seizure risk?

[Click here to enter text.](#)

Please send along with all relevant EMRs, medication lists, consults, test results, and medical/psych history to 250-381-3222.

Physicians can consult with a Mental Health & Substance Use Intake worker by calling 250-519-3485.