Office Use Only
Paris ID #: _____
Date Received: _____

Vancouver Coastal Health Richmond Community Mental Health & Substance Use Services (All Ages)
Central Intake: Phone (604) 204-1111 Fax: (604) 244-5487

REFERRAL FORM

THIS IS NOT AN EMERGENCY SERVICE. **CALL 911 FOR EMERGENCY RESPONSE.**

Client Name: _____ **PHN:** _____
Last Name *First Name*

Address: _____ **DOB:** _____ **Gender:** _____

Primary Phone: _____ **Other Phone:** _____
Can message be left? ☐ *Yes* ☐ *No* *Can message be left?* ☐ *Yes* ☐ *No*

Primary Email Address: _____ **Is the client aware of this referral?** ☐ *Yes* ☐ *No* ☐ *N/A*

Preferred Language: _____ **Interpreter Needed?** ☐ *Yes* ☐ *No*

Who to Contact to Book Appointment if not client: Name (first/last): _____ Phone: _____
Relationship (e.g. parent, Substitute Decision Maker): _____ **Is this person aware of the referral?** ☐ *Yes* ☐ *No*

Referring Source: *(name, agency, address, phone, MSP billing #)*

Primary Medical Care Provider: *(e.g. family physician, nurse practitioner - name, address, phone, MSP billing #)*

Referral Reason: ☐ Diagnostic Clarification* ☐ Medication Review* ☐ School Support+
☐ Eating Disorders Treatment* ☐ Psycho-social assessment, treatment and counselling
**requires physician, nurse practitioner or midwife referral* *+requires school counsellor referral*

Presenting Problem: *(include symptoms, duration, severity, level of functioning and contributing factors; include other relevant information such as diagnoses, client on extended leave, impairments with cognition, sleep and mood if applicable)*
***If eating disorders, specify frequency/duration of purging/restricting/exercising/laxative use, etc.*

If urgent, reason: _____

Previous professional consultations, hospital admissions or ER visits: ☐ Yes *(attach reports)* ☐ No

Note: If you have any additional collateral you would like to include (e.g. letters) please attach to this form when submitting.

PLEASE COMPLETE PAGE 2 (RISK ISSUES, MEDICAL CONDITIONS, MEDICATIONS, ETC.; LAB WORK IF APPLICABLE) →

Risk of Harm to Self: ☐ Yes ☐ No
(e.g. self-harm behaviours, using opiates alone, impulsive behaviours such as running into traffic, self-neglect)

Describe: _____

Suicidal Ideation: ☐ Active ☐ Passive ☐ None

Current Plan: ☐ Yes ☐ No

Describe: _____

Medical Conditions *(including allergies)* **and Other Risk Issues:**
(e.g. developmental delay, cognitive impairment, medically fragile, suspected abuse from others)

Risk of Harm to Others: ☐ Yes ☐ No
(e.g. homicidal ideation, escalating violence towards others such as biting/hitting/physical altercations)

Describe:

Substance Use (if applicable): ☐ Current ☐ Past

Describe *(e.g. type, frequency, amount):*

Current Medications (or attach MAR):

If applicable, date of next injection medication: _____

Other Involved Supports: *(e.g. pediatrician, MCFD)*

All referrals related to **EATING DISORDERS (other than Binge Eating Disorder)** require the following information & lab work:

Weight: Current _____(Date:)_____ Lowest _____(Date:)_____ Highest _____(Date:)_____

Height: _____ LMP (Date): _____

Please CC "THE RICHMOND EATING DISORDERS PROGRAM C#1774"

☐ General Bloodwork: CBC, FERRITIN
☐ Electrolytes including: random glucose, Na, K, CL, HCO_3, Mg, Ca, PO_4
☐ Liver Function: AST, ALT
☐ Renal Function: BUN, CREAT
☐ Thyroid: TSH
Consider offering an HIV test with this blood work.
Other ☐ ECG

☐ I understand that the Richmond Eating Disorders Program is an outpatient eating disorders service and will not assume responsibility for the primary care of this client. Ongoing care is the responsibility of the referring physician.

All referrals related to **OLDER ADULT MENTAL HEALTH TEAM** require the following information & lab work from the past 6 months:

Blood Pressure: _____(Date): _____ Pulse: _____ (Date): _____ Weight_____ (Date): _____

If labs have not been done in the past 2 weeks, please order and CC "RICHMOND OLDER ADULT MENTAL HEALTH TEAM C#0331"

☐ General Bloodwork: CBC, Differential & Morphology, B12
☐ Electrolytes including: glucose (random or fasting) and Mg
☐ Liver Function: AST, GGT
Other ☐ Urinalysis ☐ GFR
☐ Renal Function: BUN, CREAT, UREA
☐ Thyroid: TSH
Consider offering an HIV test with this blood work.

Please include if available: ☐ Chest X-ray ☐ ECG ☐ CT Head ☐ MRI

Richmond Mental Health and Substance Use Programs are non-emergency outpatient specialty services that work in partnership with referring partners (e.g. family doctors; school counsellors; social workers, etc). By signing here, I acknowledge the ongoing nature of this collaborative approach to providing services for this client - - **Referring Partner Signature**: _____