Vancouver Coastal Health
Promoting wellness. Ensuring care.

Vancouver General Hospital
Health Centre – Ground Floor
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Cross-Cultural Outpatient Psychiatry Clinic

****Please note: Incomplete / Illegible forms will not be processed**

DATE OF REFERRAL: ______________________________

CLIENT INFORMATION:

NAME: ____ PHN: ______________________________

ADDRESS: ____ DOB: ______________ GENDER: ______

PRIMARY PHONE: ______________________________ (can message be left yes no)

OTHER: ____________________ (can message be left yes no)

Next Of Kin: ____ Relationship: ______________________________

** Language Spoken / Cultural Background: ______________________________

**Canadian Status:

Citizen Landed immigrant Refugee Claimant Visitor Student Visa Other ____________________

REFERRING SOURCE: (name, address, phone, **fax**, billing #)

PRIMARY CARE PHYSICIAN: (name,address, phone, **fax**, billing #)

PRESENTING PROBLEMS:

Symptoms: ____

Duration: ____

Severity: ____

Contributing Factors: ____

REFERRAL REASON:

- ☐ **Diagnostic Clarification / Consultation**
- ☐ **Medication Review**
- ☐ **Treatment**
- ☐ **Recommendations**

Previous Psychiatric Involvement: (attach documentation) ☐ Yes ☐ No ☐ Unknown

Current Diagnosis ☐ No ☐ Yes Describe ____

Presenting Problem	Dates	Hospitalized?

CURRENT MEDICATION & DOSAGE: (Or attach list)

____
____
____

MEDICAL CONDITIONS: (Include allergies & medical surgeries)

____
____
____

Legal Charges / Involvement: No Yes (describe)

____

ICBC / WCB Claim #: ______________________________

Family Issues: No Yes (describe)

____

Employment Issues:

Current Employment? No (describe) ☐ Yes

____

Aggression: (verbal or physical) Current Past

Describe:

____

Substance Use: Current Past

Describe: ____

Suicidal Ideation: Active Passive None

Current Plan: Yes No

Attempts: Multiple One None

Lethality: High Moderate Low

Date of last attempt: ______________________________

Self Harm: Current Past

Describe: ____