Vancouver CoastalHealth
Promoting wellness. Ensuring care.

Vancouver Adult Mental Health Intake Referral Form
Phone: 604.675.3997
Fax: 604.215.3664

*********For URGENT referrals with active suicidal ideation or plan*********
Please call Mental Health Emergency Services (MHES) at 604.874.7307 or 911

REFERRAL TO: ❑ Community Mental Health Intake ❑ VGH Outpatient Psychiatry Team ❑ Acute Home-Based Treatment

PLEASE PRINT CLEARLY – Incomplete/illegible forms will not be processed. **Date of Referral:**

CLIENT INFORMATION:

Name: Last _____ First _____ **PHN**: _____ **DOB**: _____ (dd/mm/yyyy)

Address: _____ **Phone:** _____ **Gender**: ❑ M ❑ F ❑ Other

Next of Kin: _____ **Relationship to Client:** _____ **Phone:** _____

Language: _____ **Is interpreter required?** ❑ No ❑ Yes **Is client aware of this referral?** ❑ No ❑ Yes

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

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

PRESENTING PROBLEMS:
(symptoms, duration, severity and contributing factors)

REFERRAL REASON:
(diagnostic clarification, consultation, treatment or recommendations)

CLINICAL FEATURES:

If imminent risk to self or others contact MHES or 911

1. **Suicidality:**
   Ideation: ❑ No ❑ Active ❑ Passive
   Plan: ❑ No ❑ Yes: _____
   Attempts: ❑ No ❑ One ❑ More than one
   Date of last attempt: _____
   Lethality of attempts: ❑ Low ❑ Moderate ❑ High
2. **Self Harm Behaviour:**
   Current? ❑ No ❑ Yes: _____
   Past? ❑ No ❑ Yes: _____
3. **Aggressive Behaviour:**
   Toward others? ❑ No ❑ Yes: _____
   Toward property? ❑ No ❑ Yes: _____
4. **Legal Charges/Involvement:** ❑ No ❑ Yes (describe):
   _____
5. **Family Issues:** _____
   _____
6. **Employment Issues:** _____
   _____
7. **Functional Concerns:** (self-care/hygiene, budgeting/finances, homemaking, eating/meal preparation, daily activities)
   _____
   _____
   _____
   _____
8. **Referrals/Waitlisted for other services?:** ❑ No ❑ Yes
   List other involved care providers: (GP, Psychiatrist, MH Worker, Counsellor, Therapist etc.)
   _____
   _____
9. **Current Medication List:**

Medication Name	Dose

10. **Allergies:** _____
11. **Medical Issues:**
    _____
    _____
12. **Previous Psychiatric Involvement** (attach documentation):

Presenting Problem	Dates	Hospitalized?

13. **Substance Use** (alcohol & drug): ❑ Current Use ❑ Past Use

Type	Quantity	Frequency