Child Youth & Family Mental Health Services
Queen Alexandra Centre for Children's Health
2400 Arbutus Road Victoria BC V8N 1V7

Tertiary Outpatient Services Referral Form

Please select ONE only

☐ **Anscomb Outpatient Program** ☐ **Adolescent Intensive Day Treatment Program** ☐ **DBT**

MANDATE

The primary mandate of Child, Youth & Family Mental Health Outpatient Services is to provide tertiary-level treatment and/or assessment services to children, youth and their caregivers. Anscomb program is a regional service, while our specialized treatment programs (AIDT & DBT) are available south island only.

ELIGIBILITY CRITERIA

- Anscomb ages 5-18; AIDT ages 14-18; DBT ages 17 & 18
- Significant challenges in daily functioning due to severe, complex and persistent mood, anxiety and/or behavioural conditions related to major psychiatric disorders.
- Child/Youth and caregiver needs have exceeded resources in community.
- Ongoing involvement of community physicians and mental health professionals is essential.
- Family commitment and participation in services provided is essential.

REFERRAL PROCESS

1. **Complete three-page form (please print) and fax to (250) 519-6789. The consent portion of this form must be signed by the legal guardian and child 12 years and older before the referral will be considered.**
2. If you wish to discuss the referral before submitting, phone intake (250) 519-6720 or (250) 519-6794.
3. Additional documentation in regard to program admission criteria may be requested. Fax relevant reports and assessment documents to **Intake** at (250) 519-6789
4. **South Island:** Referrals are accepted from the Ministry of Children & Family Development – Child and Youth Mental Health (CYMH).
5. **Central and North Island:** Referrals are accepted from physicians and mental health clinicians.

Referral Source – Referring Physician or Mental Health Clinician		
Name:		**Phone#:**
Address:		**Fax#:**
Patient Information		
Full Legal Name:		
Preferred Name:		**DOB:**
Current Address:		
City:	**Province:**	**Postal Code:**
	Phone #:	**Cell #:**
Gender: ☐ **Female** ☐ **Male** ☐ **x Gender** ☐ **Prefer not to disclose**		**Preferred pronoun: She/her He/him They/them**
Do you self-identify as Indigenous? Yes ☐ **No** ☐		
PHN:	**School:**	**School Phone #:**
Parent/Guardian Information		
Legal Guardian Name:		**Relationship to Patient:**
Current Address:		**Phone#:**
City:	**Province:**	**Postal Code:**
Patient resides with (if different):		**Relationship to Patient:**

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Consent *To Be Signed By Legal Guardian & Youth 12 Years and Older*

I _____*(Legal Guardian)* and _____*(Child/Youth 12yrs+)*
Give consent to CYFMHS employees to receive and share information related to the mental health assessment & treatment needs of _____ with other professionals in order to facilitate the provision of continuing care.

Signature of Guardian: _____ **Date Signed:** _____

Signature of Child/Youth: _____ **Date Signed:** _____

Signature of Witness: _____ **Date Signed:** _____

Referral Information:

What is the reason for this referral: Please specify the severity of current psychiatric concern AND impact on functioning. Please indicate diagnosis/relevant medical history. **(please attach copies of relevant reports):**

☐ Family work/support	☐ Individual/Family treatment
Multidisciplinary assessment ☐ Psychology ☐ OT ☐ Speech & Language	☐ Community/School consultation

ARE THERE ANY CURRENT SAFETY CONCERNS? Please specify:

☐Self-harm ☐Suicidal ideation ☐Aggression ☐Suicide Attempts

What are the PSYCHIATRIC CONCERNS? (Please check all that apply)

☐ Anger/Oppositional behaviour	☐Hallucinations/Delusions/Psychosis	☐Peer Relationship Difficulties
☐Anxiety	☐Hyperactivity	☐School Difficulties
☐Behaviour/Disregulation	☐Inattention	☐Sleep Problems
☐Depression/Mood	☐Learning Difficulties	☐Substance Use
☐Developmental Delay	☐Obsessions/Compulsions	☐Other (please describe)

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CURRENT MEDICATIONS (including dosage):

How can we best meet this client's cultural and/or spiritual needs?

Has this patient been referred to any other programs? If yes, please specify:

Which of the following professionals has this patient seen previously and at present:

Relationship Type	Name	Contact (phone/email)	Current involvement
☐ Family Physician:			
☐Pediatrician:			
☐Psychiatrist:			
☐Psychologist:			
☐Counsellor:			
☐Community Mental Health Team:			
☐ Other professionals/ programs involved? (if yes, please specify name and contact information):			

Please indicate who will be following up with this patient after Ledger admission is completed:

1. **Prescribing Physician (if indicated): _____**
2. **Community Clinician/Case Manager: _____**