Tertiary Mental Health Referral (Adults and Senior)

****Please complete ALL SECTIONS of this form to avoid processing delays****

Name: Date of Birth: MOST: M1 M2 M3 C0 C1 C2 Indigenous: Yes No MHA Certified: Yes No

MRN: PHN:

Referring psychiatrist: (Responsible for presentation to TAC) MRP:

Family Contact/SDM: SDM Contact #:

Consent from client/SDM Obtained: ☐ Income Source:

Clinician involved in completing application: Contact #:

Community Team responsible for discharge planning and support:

Client's location at time of referral: Date Referral Completed:

Please include the following when submitting this referral form:

- ☐ Current VBACT Score Sheet
- ☐ Behaviour Care Plan(s)
- ☐ Current MAR
- ☐ Comprehensive typed psych history (< 12 months old) [on Powerchart ◉ or Attached ○]
- ☐ Recent typed psych consult outlining treatment goals [on Powerchart ◉ or Attached ○]
- ☐ Violence Alert activation form (if available)
- ☐ HROV (if available)
- ☐ DOS charting (if available)

For paper charts only:

- ☐ Past 7 days of interdisciplinary and physician notes

Psychiatric diagnosis:

Goal(s) for referral to tertiary MH services (including why secondary/residential level of care is not appropriate):

What has previously been tried and what were outcomes:

Medical history, including any current specialist involvement:

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Clinical Frailty Scale score (*if applicable)*:

History of security services intervention:

If applicable, when security intervention was last required:

History of aggression (severity, frequency, predictability):

1:1 use (past 30 days):

If applicable, number of hours per day:

History of restraint use (describe type- *i.e., Pinel, posey belt/mittens, HTR/Broda chair, fixed tray table* and frequency):

History of seclusion room use (past 30 days):

Suicide risk: ◉ Low ○ Medium ○ High

Cigarette smoker: ◉ Yes ○ No

Willing to quit? ◉ Yes ○ No ○ Unknown

(All Seniors sites are non-smoking)

Substance use (type, frequency):

Cognitive impairment (comment on severity and whether it is progressive):

Cognitive/functional testing with dates (i.e., MoCA/MMSE score):

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Functions needing assistance:

ADLs: ☐ Dressing ☐ Feeding ☐ Toileting ☐ Personal Care ☐ Mobility

IADLs: ☐ Banking ☐ Driving ☐ Way finding ☐ Medications ☐ Meal Prep ☐ Budgeting

Number of staff needed for personal care: ☐ Lift required

Mobility:
- ○ Independent, without equipment
- ○ Independent, with equipment
- ◉ Dependent on others

Required Aids: ☐ Wheelchair ☐ Geri Recliner ☐ Walker Other: ☐ Cane

Falls assessment score and date of assessment:

Wandering/intrusive behaviours (frequency and severity):

Sexual behaviour:

Environmental requirements (i.e., level of stimulation/size of unit):

Team to be involved with discharge (from tertiary) planning and likely location:

Other considerations:

Please send completed form and collateral (**not including Powerchart documents**) via email to: MHSUTertiaryAccess@IslandHealth.ca

If unable to send by email, please contact Tertiary Access at the above email for alternatives