# MENTAL HEALTH & SUBSTANCE USE INTAKE REFERRAL FORM (FOR PATIENTS 19+)

**PLEASE PRINT LEGIBLY - FAX all pages either to**
**Victoria CARES 250-381-3222 or Westshore CARES 250-370-5724.**

## PATIENT INFORMATION – if this information is not completed the referral will not be processed

**Name:** *Last*_____ *First*_____ *Preferred name*_____

**Sex:** Female ☐ Male ☐ Intersex ☐ Prefer Not to Answer ☐

**Gender:** Woman/girl ☐ Man/boy ☐ Non-binary ☐ Unknown

**DOB (dd-mm-yyyy):** _____ **PHN:** 9_____ **MRN #:** _____

**Phone #:** *Primary*: _____ *Secondary*:_____ *Ok to leave messages?* Y ☐ N ☐

**Address:** _____

**E-mail address (optional):** _____

## REFERRAL INFORMATION – if this information is not completed the referral will not be processed

Date of Referral: _____

Referring Physician: _____

Referring Clinic: _____

Clinic Phone: _____ Fax: _____

Medical Professionals Line: _____

Best time to reach referring Physician:_____

*Place Sticker Here*

Primary Care Physician (if different from referring physician): _____

If the patient is referred to Psychiatry or CBT Skills Group are you willing to remain MRP? Y ☐ N ☐

## CURRENT CLINICAL FEATURES – Please check all that apply, then provide any additional information

### URGENCY:

☐ Non-Urgent / Routine
☐ Semi-Urgent / Moderate
☐ Urgent

*IF RISK REQUIRES AN IMMEDIATE RESPONSE, PLEASE REFER TO IMCRT (MOBILE CRISIS TEAM) via Confidential Pager for professionals only **250- 361-5958** after 1300 hours OR TO THE EMERGENCY ROOM, OR CALL 911.*

### HIGH-RISK SYMPTOMS:

☐ Risk of harm: ☐ To self ☐ Others ☐ Plan?
☐ Suicide / homicide risk assessment completed by referring physician?
☐ Psychotic Symptoms
☐ Behaviour influenced by delusions/hallucinations
☐ Patient is experiencing command hallucinations
☐ Substance Use – increased and/or excessive
☐ Falls/mobility risks
☐ Child protection concerns; MCFD contacted? _____

### SYMPTOMS:

☐ Pronounced and/or Resistant Depression
☐ Manic/Hypomanic Symptoms
☐ Major Cognitive Impairment/Disorganization
☐ Suicide attempt history
☐ Chronic Emotional/Behavioural Instability
☐ Generalized Anxiety
☐ Panic Attacks
☐ Social Phobia
☐ Obsessive/Compulsive Behaviour

**Assessments primarily for ADHD and Autism spectrum disorders not provided by this clinic.**

**SYMPTOM DETAILS, HISTORICAL CONTEXT, CURRENT STRESSORS:**
Click here to enter text.

**REASON FOR REFERRAL**

**PREVIOUS MHSU SERVICE HISTORY:** ☐ Within IH ☐ Elsewhere:_____

**LIST MHSU SUPPORT SERVICES PREVIOUSLY OR CURRENTLY RECEIVING:**
Click here to enter text.

**REFERRING PHYSICIAN SUSPECTED DIAGNOSIS:**
Click here to enter text.

**IF KNOWN, TYPE OF MHSU SUPPORT SERVICE SEEKING:**

☐ Psychiatric Referral ☐ Substance Use Counselling
☐ Single Session Therapy ☐ Detox
☐ Mental Health Counselling ☐ Other _____

Is patient supportive of this referral? Y ☐ N ☐
Would patient like to receive service in the Westshore? (MHSU Westshore service is for mild/moderate needs only) Y ☐ N ☐

**MEDICATIONS:**

| Name | Date started | Amount | Frequency |
|---|---|---|---|
| Click here to enter text. | | | |

Adverse reactions/allergies?
Click here to enter text.

Problems affording medications?
Click here to enter text.

**SUBSTANCE USE:**

| Substance | Date last used | Amount | Frequency |
|---|---|---|---|
| Click here to enter text. | | | |

Is there withdrawal/seizure risk due to use of alcohol and/or benzodiazepines?
Click here to enter text.

**Please send along with all relevant EMRs, medication lists, consults, test results, and medical/psych history to either Victoria CARES fax 250-381-3222 or Westshore CARES fax 250-370-5724.**

**Physicians can consult with a Mental Health & Substance Use Intake worker by calling Victoria CARES at 250-519-3485 or Westshore CARES at 250-370-5799.**

# MHSU CLIENT QUESTIONNAIRE

**TO BE FILLED OUT BY PATIENT OR CARE PROVIDER**

PLEASE PROVIDE AS MUCH INFORMATION AS YOU FEEL COMFORTABLE/SAFE SHARING

MUST ACCOMPANY PHYSICIAN MHSU INTAKE REFERRAL FORM

| **BACKGROUND INFORMATION FOR PSYCHIATRIC ASSESSEMENT** |
|---|
| **Patient Name:**_____ **Date of Birth:**_____ |
| What is your understanding of why you have been referred to psychiatric services by your family physician or nurse practitioner and what do you hope to get from an assessment:<br>Click here to enter text. |
| Place of birth and where did you grow up:<br>Click here to enter text. |
| Highest Level of education:<br>Click here to enter text. |
| Source of Income:<br>Click here to enter text. |
| Information about employment (type of work, hours, retired, etc.):<br>Click here to enter text. |
| Relationship status (how long, concerns, etc.):<br>Click here to enter text. |
| Housing (stable housing, own or rent, etc.):<br>Click here to enter text. |
| Children (number and ages):<br>Click here to enter text. |

History of mental health or substance use services (when, how long, where, etc.):
Click here to enter text.

Previous psychiatry/previous diagnosis (when, where, what, etc.):
Click here to enter text.

Substance use, including alcohol, tobacco, cannabis, street drugs, misuse of over-the-counter medication, misuse of prescription medication (including how much, how often, route of injection, etc.):
Click here to enter text.

Physical health concerns:
Click here to enter text.

Previous or current legal issues:
Click here to enter text.

History of trauma/abuse:
Click here to enter text.

Family history of mental health or substance misuse concerns (diagnosed or suspected):
Click here to enter text.