

Office Use Only  
Paris ID #: \_\_\_\_\_  
Date Received: \_\_\_\_\_



Vancouver Coastal Health Richmond Community  
Mental Health & Substance Use Services (All Ages)  
Central Intake: Phone (604) 204-1111 Fax: (604) 244-5487

### REFERRAL FORM

**THIS IS NOT AN EMERGENCY SERVICE.**

**CALL 911 FOR EMERGENCY RESPONSE.**

**Client Name:** \_\_\_\_\_ **PHN:** \_\_\_\_\_  
*Last Name First Name*

**Address:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Gender:** \_\_\_\_\_

**Primary Phone:** \_\_\_\_\_ **Other Phone:** \_\_\_\_\_  
*Can message be left?  Yes  No*

**Primary Email Address:** \_\_\_\_\_ **Is the client aware of this referral?**  Yes  No  N/A

**Preferred Language:** \_\_\_\_\_ **Interpreter Needed?**  Yes  No

**Who to Contact to Book Appointment if not client:** Name (first/last): \_\_\_\_\_ Phone: \_\_\_\_\_  
Relationship (e.g. parent, Substitute Decision Maker): \_\_\_\_\_ **Is this person aware of the referral?**  Yes  No

**Referring Source:** (name, agency, address, phone, MSP billing #)

**Primary Medical Care Provider:** (e.g. family physician, nurse practitioner - name, address, phone, MSP billing #)

- Referral Reason:**  Diagnostic Clarification\*  Medication Review\*  School Support\*  
 Eating Disorders Treatment\*  Psycho-social assessment, treatment and counselling  
*\*requires physician, nurse practitioner or midwife referral +requires school counsellor referral*

**Presenting Problem:** (include symptoms, duration, severity, level of functioning and contributing factors; include other relevant information such as diagnoses, client on extended leave, impairments with cognition, sleep and mood if applicable)

*\*\*If eating disorders, specify frequency/duration of purging/restricting/exercising/laxative use, etc.*

If urgent, reason: \_\_\_\_\_

**Previous professional consultations, hospital admissions or ER visits:**  Yes (attach reports)  No

*Note: If you have any additional collateral you would like to include (e.g. letters) please attach to this form when submitting.*

**PLEASE COMPLETE PAGE 2 (RISK ISSUES, MEDICAL CONDITIONS, MEDICATIONS, ETC.; LAB WORK IF APPLICABLE) →**

<p><b>Risk of Harm to Self:</b>      <input type="checkbox"/> Yes    <input type="checkbox"/> No  <i>(e.g. self-harm behaviours, using opiates alone, impulsive behaviours such as running into traffic, self-neglect)</i></p> <p>Describe: _____</p> <p><b>Suicidal Ideation:</b>   <input type="checkbox"/> Active   <input type="checkbox"/> Passive   <input type="checkbox"/> None</p> <p>Current Plan:                      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Describe: _____</p>	<p><b>Medical Conditions (including allergies) and Other Risk Issues:</b>  <i>(e.g. developmental delay, cognitive impairment, medically fragile, suspected abuse from others)</i></p>
<p><b>Risk of Harm to Others:</b>      <input type="checkbox"/> Yes    <input type="checkbox"/> No  <i>(e.g. homicidal ideation, escalating violence towards others such as biting/hitting/physical altercations)</i></p> <p>Describe: _____</p>	<p><b>Substance Use (if applicable):</b>    <input type="checkbox"/> Current    <input type="checkbox"/> Past</p> <p>Describe <i>(e.g. type, frequency, amount)</i>:</p>
<p><b>Current Medications (or attach MAR):</b></p>  <p>If applicable, date of next injection medication: _____</p>	
<p><b>Other Involved Supports:</b> <i>(e.g. pediatrician, MCFD)</i></p>	
<p>All referrals related to <b>EATING DISORDERS (other than Binge Eating Disorder)</b> require the following information &amp; lab work:</p> <p>Weight: Current _____ (Date: ) _____    Lowest _____ (Date: ) _____    Highest _____ (Date: ) _____</p> <p>Height: _____    LMP (Date): _____</p> <p><b>Please CC "THE RICHMOND EATING DISORDERS PROGRAM C#1774"</b></p> <p><input type="checkbox"/> General Bloodwork: CBC, FERRITIN</p> <p><input type="checkbox"/> Electrolytes including: random glucose, Na, K, CL, HCO<sub>3</sub>, Mg, Ca, PO<sub>4</sub></p> <p><input type="checkbox"/> Liver Function: AST, ALT</p> <p><input type="checkbox"/> Renal Function: BUN, CREAT</p> <p><input type="checkbox"/> Thyroid: TSH</p> <p><i>Consider offering an HIV test with this blood work.</i></p> <p><b>Other</b>    <input type="checkbox"/> ECG</p> <p><input type="checkbox"/> I understand that the Richmond Eating Disorders Program is an outpatient eating disorders service and will not assume responsibility for the primary care of this client. Ongoing care is the responsibility of the referring physician.</p>	
<p>All referrals related to <b>OLDER ADULT MENTAL HEALTH TEAM</b> require the following information &amp; lab work from the past 6 months:</p> <p>Blood Pressure: _____ (Date: ) _____    Pulse: _____ (Date: ) _____    Weight _____ (Date: ) _____</p> <p><b>If labs have not been done in the past 2 weeks, please order and CC "RICHMOND OLDER ADULT MENTAL HEALTH TEAM C#0331"</b></p> <p><input type="checkbox"/> General Bloodwork: CBC, Differential &amp; Morphology, B12</p> <p><input type="checkbox"/> Electrolytes including: glucose (random or fasting) and Mg</p> <p><input type="checkbox"/> Liver Function: AST, GGT</p> <p><b>Other</b>   <input type="checkbox"/> Urinalysis    <input type="checkbox"/> GFR</p> <p><input type="checkbox"/> Renal Function: BUN, CREAT, UREA</p> <p><input type="checkbox"/> Thyroid: TSH</p> <p><i>Consider offering an HIV test with this blood work.</i></p> <p><b>Please include if available:</b>   <input type="checkbox"/> Chest X-ray   <input type="checkbox"/> ECG   <input type="checkbox"/> CT Head   <input type="checkbox"/> MRI</p>	
<p>Richmond Mental Health and Substance Use Programs are non-emergency outpatient specialty services that work in partnership with referring partners (e.g. family doctors; school counsellors; social workers, etc). By signing here, I acknowledge the ongoing nature of this collaborative approach to providing services for this client - - <b>Referring Partner Signature:</b> _____</p>	