Mental Health & Substance Use Intake Referral Form (For Patients 19+)
Salt Spring, Saturna, Galiano, Mayne or Pender
Fax: 250-538-4877

Name: *last*_____ *first*_____ *alias:* _____ Gender: M ☐ F ☐ Other ☐ Pronoun:_____

DOB (dd-mm-Yiyi): ___-___-_____ PHN: 9_____ Address: _____NFA: ☐

Phone # *Mobile*: _____ *Other*: _____ Email: _____

REFERRAL INFORMATION

Date of Referral: _____ Source of Referral: _____

Primary Care Provider: _____ Phone: _____ Private Line: _____ Fax: _____

Date of last physical exam: _____ Is patient supportive of this referral? Y ☐ N ☐

REASON FOR REFERRAL – Attach printout for further details

☐ *If possible, client would like to receive services on the island they reside* ☐ *Client would like to receive services virtually or in person in Victoria*

WHY IS THIS PATIENT SEEKING MENTAL HEALTH or SUBSTANCE USE SERVICES?

CURRENT CLINICAL FEATURES - *Please check all that apply*:

Risk Factors:

- ☐ Risk of harm to others ☐ plan? _____ ☐ means available
- ☐ Risk of harm to self ☐ plan? _____ ☐ means available
- ☐ Suicide attempt history ☐ method _____
- ☐ Recent actions taken to a suicide/homicide plan (e.g. writing will, procuring means, giving away belongings)
- ☐ Behaviour influenced by delusions/hallucinations
- ☐ Patient is experiencing command hallucinations
- ☐ Pronounced Self Neglect
- ☐ Serious complicating medical problem? _____

Please describe any risk factors identified:

*** IF PATIENT'S RISK REQUIRES A RESPONSE TODAY, PLEASE CONTACT IMCRT FOR A CONSULT (CRISIS TEAM LOCATED IN VICTORIA)**
Medical Professional line only 250-370-5657.
Confidential Pager for professionals only 250-361-5958.
OR GO TO THE NEAREST EMERGENCY ROOM, OR CALL 911.

- ☐ Pronounced and/or Resistant Depression
- ☐ Psychotic Symptoms
- ☐ Manic/Hypomanic Symptoms
- ☐ Major Cognitive Impairment/Disorganization
- ☐ Unstable/Lack of Housing
- ☐ Other: _____
- ☐ Chronic Emotional/Behavioural Instability
- ☐ Generalized Anxiety
- ☐ Panic Attacks
- ☐ Social Phobia
- ☐ Obsessive/Compulsive Behaviours
- ☐ Other: _____

Significant Drug/Alcohol Abuse? (Please mark below)

Substance	Typical Method	Quantity	Frequency
1.			
2.			
3.			
4.			

Previous/Current Treatments: (Including psychiatric admissions & addictions services)

Type	Dose	Date
1.		
2.		
3.		
4.		

Medical History and Investigations: (Please attach investigation results)

1.
2.
3.
4.

PLEASE DESCRIBE CURRENT SYMPTOMS AND ANY COMPLICATING FACTORS:

CURRENT MEDICATIONS:
(Attach printout of current symptoms/medications from GP Chart if preferred)

Type Dose When Initiated

1._____
2._____
3._____
4._____

Any Adverse Drug Reactions? ☐ _____

Any Problem Affording Medications? ☐ _____ Plan G initiated Yes/No

Any **Allergies?** ☐ _____

To consult with the Southern Gulf Islands MHSU team call 250-538-4711

Office located at #202-321 Lower Ganges Road, Salt Spring Island, BC V8K 2V4

Resources for physicians

Rapid Access to Consultative Expertise 1-877-696-2131 - Mon-Fri 0800-1700

Addiction Medicine Specialist 1-778-945-7619 – 24 x 7