Interior Health
Every person matters

VERNON MENTAL HEALTH & SUBSTANCE USE

REFERRAL FORM

PLEASE FAX FORM TO: 250-549-6358

Name *(Last, First Initial):*	☐ F ☐ M ☐ Other_____	**DOB** **(dd/mm/yyyy):**
Is patient aware and in agreement with the referral ☐ Yes ☐ No If no please do not proceed with referral		
PHN:	Phone number:	Can leave a message? ☐ Yes ☐ No
Address:		
Referring Physician Name:	MSP Billing #:	
Address:		
Phone #:	Fax #:	

ALL REFERRALS WILL BE SCREENED FOR APPROPRIATENESS	
We are <u>not</u> able to accept referrals for assessment/treatment where concerns are primarily related to: **Anger management Chronic Pain Relationship Counselling Bereavement**	
As we are unable to provide assessments for: **Legal, Insurance, Custody, MCFD Child Protection or, Forensics** please confirm that this is not the reason for the referral ☐ Confirmed	
SERVICE REQUESTED:	
Psychiatric Consult:	**Other services at Vernon Mental Health & Substance Use:**
☐ Diagnostic clarification	☐ Mental Health Counselling
☐ Medication Review	☐ Substance Use Counselling
☐ Short Term Management	
☐ 10 min. MD/NP to MD phone consultation	Does this patient have access to private counselling (ie EFAP)? ☐ Yes ☐ No (***If yes please have patient access that service***)

What has prompted a referral at this time and what is the specific question being asked?
Specify current symptoms and comment if a change in level of function has occurred. (If referring for counselling services please indicate the patient's goal(s) for therapy)

RISK AND SAFETY CONCERNS:				
Risk:	**Yes**	**No**	**If yes when (DD/MM/YYYY):**	**Details:**
Threat to self	☐	☐		
Threat to others	☐	☐		
Suicidal ideation / Plan / Intent	☐	☐		
Violent Behaviour	☐	☐		
Caring for dependents / pregnant	☐	☐		

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CURRENT MEDICATION: (or attach current MAR)			
Medication	Dose	Medication Start Date	Response

ALLERGIES:

PREVIOUS PSYCHIATRIC MEDICATION TRIALS:

Medication including dose	Duration taken	Response / Adverse Effects/ Reason for discontinuing

MEDICAL HISTORY:

Please attach any relevant consultations or imaging reports
Please attach recent bloodwork (within last 2 months) including CBC, ferritin, fasting glucose, TSH, kidney and liver panels, Vit B12

SUBSTANCE USE: (Indicate current substance, amount and frequency of use)

Current substance use led to recent problems? ☐ YES ☐ NO	If yes how?

Incomplete referral forms will be returned

Vernon MHSU accepts referrals for patients living within the Vernon catchment area *ONLY*

If your patient needs immediate help, please direct them to the nearest emergency department

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