Child and Adolescent Mental Health
Outpatient Psychiatry Programs Referral Form

MANDATE

The Outpatient Psychiatry Department (OPD) is part of the Child, Youth, and Young Adult Mental Health and Substance Use Program at BC Children's Health Centre. The OPD provides evidence-informed, psychiatric and multidisciplinary consultation and treatment to children and adolescents. Our primary mandate is to provide **tertiary level service** for children and youth with complex psychiatric concerns.

If you are looking for support and clinical consultation, Compass can provide advice and support with diagnostic clarification, medication recommendations and treatment planning . Visit www.compassbc.ca or call 1 855-702-7272 Monday to Friday 9am-5pm

For general information on mental health issues and community resources visit the Kelty Mental Health Resource Centre

Please note: Boxes in red are mandatory.

In the box below, provide all consult reports and supporting documentation attached with this referral form:

PATIENT INFORMATION Referral Date:

Child/Youth Surname: First Name:

DOB: (MM/DD/YYYY) Email: Phone No: PHN:

Gender: ☐Female ☐Male ☐Non-Binary ☐Transgender ☐Other: Pronouns: He/Him

First Nations, Metis, Inuit ☐Yes ☐ No ☐ Status ☐ Non-status (Band/Nation/Community):

Address: Postal Code:

Contact Person: Relationship:

Contact Person Phone: Interpreter required: ☐Yes ☐No Language:

PARENT, LEGAL GUARDIAN or ORGANIZATION (include all guardians):

Name: Relationship: Phone: ☐ Legal Guardian

Name: Relationship: Phone: ☐ Legal Guardian

Child Resides with: ☐ Please tick here if **ALL** legal guardians **Consent** (verbal) to this referral and to gather collateral for intake processes. If no, please specify why:

Cultural considerations? (i.e. refugee status) Yes ☐ No ☐ Other:

REFERRING DOCTOR INFORMATION:

Referring Practitioner Billing Number:

☐ Family Physician ☐ Nurse Practitioner ☐Pediatrician ☐ Psychiatrist ☐Other

*note if pediatrician or psychiatrist is checked, please include your consult report to ensure processing, otherwise referral form will be returned

Address:

Phone: Fax:

Are there any CURRENT SAFETY CONCERNS?

☐ Self-harm (e.g. cutting, burning) ☐ Suicide attempt(s) ☐ Suicidal ideation

If checked, please provide more information (when, how, Has a safety plan been completed? Who completed the safety plan)

☐ **CURRENT** Aggression ***For aggression concerns please indicate:**

Aggression Type:

☐ Verbal ☐ Property ☐ Physical to others ☐ Self-Injurious Behaviour (e.g.: head bangs, biting self)

☐ Risk of Family Breakdown ☐ Other:

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REASON FOR REFERRAL?

Assessment

MAIN PRESENTING CONCERNS?

Parent and child relationsh

Is there a psychiatric history ? ☐ Yes ☐ No

If yes, please include relevant psychiatric history and information:

Is there a history of substance use? Yes ☐ No ☐ Details:

If there is a diagnosis of the following? (if selected, please attach relevant reports):

☐ FASD ☐ ASD ☐ Intellectual disabilities. If checked indicated mild/moderate/severe_____

Has this patient seen any of the following in the last six months If checked provide name, date seen, and contact information

Pediatrician	☐ Name:_____	Date seen:_____	Contact info:_____
Psychiatrist	☐ Name:_____	Date seen:_____	Contact info:_____
Community CYMH Team	☐ Name:_____	Date seen:_____	Contact info:_____
Private psychologist or counsellor	☐ Name:_____	Date seen:_____	Contact info:_____
Substance use Counsellor	☐ Name:_____	Date seen:_____	Contact info:_____

Is the patient/family willing to attend group therapy before or in conjunction with psychiatric consultation? No

Medical diagnosis/relevant medical history

_____

CURRENT MEDICATIONS (*including dosage, length, medical trials and responses*):

Dose	Start date	Comments

_____

Please fax Referral Form (Page 1 and 2) and send copies of all relevant consults, reports, and medical investigations to: **FAX: 604-875-2099**

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