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Fraser North West Mental Health and Substance Use Services - Referral

Phone #: **604-520-4662** Fax #: **604-520-4871**

Patient / Client Information	**Last Name:**			**First Name:**				
	Phone:			**Cell:**				
	Address:			**PHN:**				
	DOB:			**Gender:**	☐ M	☐ F	☐ Other	
	Primary Language: (if other than English)			**Interpreter Required:**	☐ Yes		☐ No	
Emergency Contact:	**Name:**		**Phone:**		**Relationship**:			
Other Agency Involvement:	☐ WSBC	☐ ICBC	☐ MCFD	☐ BC MHSUS	☐ Corrections			
	Other:							

GP / Referrer Information	**Name:**		**MSP #:**	
	Phone:		**Fax:**	
	Address:		**Role / Agency: (if other than GP)**	

Date of referral:		**Reason for referral:**			
Expectations for referral:	☐ Consult with treatment recommendations	☐ Assessment and team care (if appropriate)	☐ Diagnosis Clarification	☐ Medication Review	☐ Group Therapy

Assessments (please attach copies of all assessments)	PHQ9	GAD7	Edinburgh Postnatal Depression Scale	Previous MHSU assessments	Previous Psychiatry consults
	Score:	Score:	Score:	☐ Yes ☐ No	☐ Yes ☐ No
Presenting Issues:	☐ Depression	☐ Anxiety	☐ Schizophrenia	☐ Psychosis	☐ Bipolar Disorder
	☐ Psychosocial Issues	☐ Suicidal Ideation	☐ Substance Use / Abuse	☐ Personality Spectrum	☐ Perinatal Depression/Anxiety
	☐ PTSD	☐ Eating problems	Other:		
Current Medications:					
Previously Trialed Medications:					
Adverse reactions to Medications:					
Other Medical Conditions:					
Other Medications:					

Risk Assessment:	**Priority:**	☐ High	☐ Medium	☐ Low	☐ Urgent
	Self Harm:	☐ High	☐ Medium	☐ Low	
	Harm to others / aggression:	☐ High	☐ Medium	☐ Low	
Details / Specific information:					