mind mood
Clinical Care Network

fax: 1-833-333-1809
www.mindandmoodbc.ca

REFERRAL FORM Psychiatric Services

Thank you for your referral for psychiatric consultation/assessment for adults with mood or anxiety disorders. Please complete all sections of this form before submission. Accurate and thorough information helps us better understand the patient's needs and coordinate appropriate services.

INCOMPLETE REFERRALS WILL NOT BE ACCEPTED AND WILL BE RETURNED

Referring physician information

Name: _____ MSP Number: _____

Office Address: _____

Office Phone: _____ Office Fax: _____

Patient information

First Name: _____ Last Name: _____

MSP: _____ Date of Birth: _____

Assigned Sex at Birth: _____ Gender: _____ Pronouns: _____

Phone: _____ Email: _____

Address: _____

Eligibility criteria

Before sending the referral, please confirm the following by checking each box:

- ❑ Patient is aged 19 years or older
- ❑ Patient has a primary mood or anxiety disorder
- ❑ Primary reason for referral is not for the assessment and/or treatment of ADHD or autism spectrum disorders
- ❑ Patient does not have active or persistent psychosis
- ❑ Patient is not an acute safety risk (suicide, aggression)
- ❑ Patient has a full-service primary care provider
- ❑ Has not had a psychiatric consultation or care within the past 6 months
- ❑ Patient is NOT being referred for the purpose of disability claims or medicolegal proceedings
- ❑ Relevant EMR notes, previous consults, and hospital discharge summaries attached
- ❑ Patient is willing to be seen via secure DOBC Zoom for Healthcare
- ❑ Patient is willing to attend group medical visits for post-consultation psychiatric care

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Medical information

Reason for referral: _____

_____

_____

Psychiatric diagnosis: _____

_____

Aggresive behaviour? Yes ❑ No ❑ If yes, please describe behaviour(s) and whether it is current or past: _____

Suicidal behaviour? Yes ❑ No ❑ If yes, please describe behaviour(s) and whether it is current or past:

_____

Psychotic behaviour? Yes ❑ No ❑ If yes, please describe behaviour(s) and whether it is current or past: _____

Substance Use? Yes ❑ No ❑ If yes, please describe behaviour(s) and whether it is current or past:

_____

Current medications and allergies (if any): _____

_____

Has the patient had previous contact with mental health professionals including school counselors, psychologists, or social workers? Yes ❑ No ❑

If yes, please list the professionals and whether there is ongoing contact:

_____

_____

Please attach records or if unavailable, please clarify whether efforts have been made by your office to obtain: _____

_____

Attach relevant information such as EMR notes, previous consults, and hospital discharge summaries.

PLEASE FAX COMPLETED FORM AND ANY ATTACHMENTS

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