

**\*\*\* For immediate and/or urgent needs please call AAC: 604-875-8289\*\*\***

REFERRAL DATE:

Client information:			
Name: Last	First	PHN:	DOB: DD MM YYYY
Address: *** Only for Vancouver Residents ***		Phone 1: Phone 2:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other
Next of Kin:	Relationship to client:	Phone 1: Phone 2:	
Primary Language:	Interpreter required? <input type="checkbox"/> Y <input type="checkbox"/> N	Canadian Citizenship <input type="checkbox"/> Y <input type="checkbox"/> N <b>if no, STATUS:</b>	
Referring Source: (name, phone, fax, billing #)		Primary Care Physician (name, phone, fax, billing #):	
Referral Reason & Goals for Treatment (diagnostic clarification, consultation, treatment or recommendations): _____ _____			
Presenting Problem/ Current Diagnosis: _____ _____			
Risk Assessment			
Suicidality/ Self-Harm	<input type="checkbox"/> Y <input type="checkbox"/> N Details & risk mitigation: _____ History (recent & remote, include dates: _____ Lethality: _____		
Aggressive Behaviour	<input type="checkbox"/> Y <input type="checkbox"/> N Details & risk mitigation: _____		
Legal Charges/ Involvement	<input type="checkbox"/> Y <input type="checkbox"/> N Details: _____		
Substance Use	<input type="checkbox"/> Y <input type="checkbox"/> N Details: _____		
Medical Issues that will impact psychiatric treatment? <input type="checkbox"/> Y <input type="checkbox"/> N Details: _____			
List current medication(s) or attach MAR: _____			
Functional Concerns: (self-care/hygiene, finances, homemaking, eating/ meal preparation, daily activities): _____ _____			
Social history (family supports, housing MCFD involvement, employment, income source etc.): _____ _____			
To be complete by Hospital Units only			
Extended Leave	<input type="checkbox"/> Y <input type="checkbox"/> N	Next Review Date: _____	Review panel Hearing Scheduled? <input type="checkbox"/> Y <input type="checkbox"/> N Date: _____
Long acting depot	<input type="checkbox"/> Y <input type="checkbox"/> N	Medication: _____	Last administered: _____ Next due: _____
Plan G Coverage	<input type="checkbox"/> Y <input type="checkbox"/> N	Expiry date: _____	Special Authority <input type="checkbox"/> Y <input type="checkbox"/> N Name of medication: _____
<b>ATTACH MOST RECENT PSYCHIATRIC ASSESSMENT</b> <input type="checkbox"/>			