Vancouver CoastalHealth

Access & Assessment Centre: A service for Vancouver Residents
Referral Form
Phone 604-675-3700 Fax 604-675-3705

***** For immediate and/or urgent needs please call AAC: 604-675-3700*****

REFERRAL DATE:

Client information:			
Name: Last First		PHN:	DOB: DD MM YYYY
Address: *** Only for Vancouver Residents ***	Phone 1: Phone 2:		Sex: ☐ M ☐ F ☐Other Pronoun:
Next of Kin:	Relationship to client:	Phone 1: Phone 2:	
Primary Language:	Interpreter required? ☐Y ☐N	Canadian Citizenship ☐Y ☐N **if no, STATUS:**	
Referring Unit and Clinician (name, phone, fax)	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	☐Y ☐N Details & risk mitigation: _____ History (recent & remote, include dates: _____ Lethality: _____
Aggressive Behaviour	☐Y ☐N Details & risk mitigation: _____
Current Therapeutic Involvement	☐ Psychiatrist ☐ Counsellor ☐ GP ☐ MHT ☐ Other _____
Legal Charges/ Involvement	☐Y ☐N Details: _____
Substance Use	☐Y ☐N Details: _____
Medical Issues that will impact psychiatric treatment? ☐Y ☐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 completed by Hospital Units Only

Extended Leave ☐Y ☐N Next Review Date: _____ Review panel Hearing Scheduled? ☐Y ☐N Date:
Long acting depot ☐Y ☐N Medication: _____ Last administered: _____ Next due: _____
Plan G Coverage ☐Y ☐N Expiry date: _____ Special Authority ☐Y ☐N Name of medication: _____

ATTACH MOST RECENT PSYCHIATRIC ASSESSMENT ☐