MOOD DISORDERS ASSOCIATION OF BRITISH COLUMBIA

A BRANCH OF Lookout Housing + Health Society

Adult Psychiatric Clinic Referral Form

PLEASE FAX to 604-873-3095

Patient Information

NAME: Last_____ First _____

PHN:_____DOB:_____ Gender _____ Phone: _____

Address:_____City: _____ Postal code_____

E-mail: _____

Next of Kin: _____ Relationship to Patient _____ Phone: _____

Referring Practitioner

Name: _____ MSP BILLING NUMBER _____

Office Address _____City: _____Postal Code: _____

Office Fax:_____ Office Phone:_____

Reason for Referral: Attach relevant information such as EMR notes, previous consults, and hospital discharge summaries.

_____

_____

Aggressive Behaviour? ☐ Yes ☐ No

If answering yes, please describe behavior(s) and whether it is current or past: _____

_____

Suicidal or Psychotic Behaviour? ☐ Yes ☐ No

If answering yes, please describe behavior(s) and whether it is current or past: _____

_____

Substance Abuse? ☐ Yes ☐ No

If answering yes, please describe behavior(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 answering yes, please list the professionals and whether there is ongoing contact: _____

_____