

**NORTH SHORE CHILD AND YOUTH MENTAL HEALTH SERVICES  
CENTRAL INTAKE AND URGENT RESPONSE REFERRAL**

- CENTRAL INTAKE : WALK-IN** Tues, Wed 9-12, 1-3:30 301-224 W Esplanade, NV Fax 604.987.9258  
The preferred option. Patient and family attend as above. Please give patient this form, and fax additional info as needed.
- NON WALK-IN** Phone 604.904.4336 Fax 604.987.9258  
Individualized arrangements as needed. Fax this form along with supporting information.
- URGENT RESPONSE** M-F 8-4 Phone 604.904.4336 Fax 604.987.9258  
For significant impairment in thought, mood, or behavior. 24 hour turn-around.  
6-8 Sessions for stabilization. Fax this form along with additional info as appropriate.

**Additional Background**

- All referrals managed according to DSM categories.
- Assigned to MCFD Child and Youth Mental Health **or** VCH Child and Adolescent Mental Health Service
- May be referred for psychiatric assessment and potential pharmacotherapy.
- MCFD will send fax acknowledgement of all referrals.
- Fax communication of ongoing treatment, for consenting clients.

Date \_\_\_\_\_

**Please send copies of relevant lab and consult reports**

<b>Name</b>	<b>DOB (m/d/y)</b>	<b>M/F</b>
<b>Address</b>	<b>PHN</b>	
<b>Note: Clients must live on the North Shore</b>		
<b>Phone: Home</b>	<b>Cell</b>	<b>Work</b>
<b>Best time to contact</b>	<b>Leave message:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>Contact person (if relevant):</b>	<b>Phone</b>	<b>Relationship</b>
<b>Living Situation:</b> Stable for next 3 months <input type="checkbox"/> Unstable <input type="checkbox"/>	<b>Comments</b>	
<b>Referred by</b>	Phone	Fax
<b>Family Physician</b>	Phone	Fax
<b>Reason for Referral</b>		
<b>Brief history / precipitating factors</b>		
<b>Provisional Diagnosis</b>		
<b>Previous psychiatric history:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Please elaborate or attach notes		
<b>Current Meds:</b>		
<b>Substance Use</b>		
<b>Risk Assessment:</b>	Self-Harm: Low <input type="checkbox"/> Medium <input type="checkbox"/> High <input type="checkbox"/>	Psychotic: Yes <input type="checkbox"/> No <input type="checkbox"/>
	Harm to Others: Low <input type="checkbox"/> Medium <input type="checkbox"/> High <input type="checkbox"/>	Insight: Good <input type="checkbox"/> Marginal <input type="checkbox"/> None <input type="checkbox"/>
<b>Notes:</b>		