North Shore Division of Family Practice
A GPSC initiative

vancouver coastal Health
Promoting wellness. Ensuring care.

NORTH VANCOUVER PRIMARY CARE NETWORK MENTAL HEALTH SUPPORT TEAM

Referral Criteria:

- Patients with mild to moderate mental health concerns
- Patient care needs must be appropriate for **short term** duration (**up to 8 sessions**)
- Patients who are 18 years old and over.

Exclusion criteria:

- Patients who are currently accessing similar services from another program, including VCH MHSU, ICBC or WorkSafe BC;
- Patients who have Extended Health Benefits should explore those options prior to accessing PCN services
- Patients on Extended Leave under the Mental Health Act, experiencing active psychosis &/or acute suicidal ideation;
- Patients requiring outreach services, or long term/complex trauma therapy;
- Patients seeking court-ordered evaluation or treatment.

Referrals will be triaged by a clinician within 2 weeks.

PATIENT INFORMATION

Last Name: First Name: PHN:

Date of Birth (DD/MM/YYYY): Gender: ☐ M ☐ F ☐ Other: Pronouns Used:

Address: City: Postal Code:

Home Phone: Cell: Email:

Has patient consented to referral? ☐ Y ☐ N

Does your patient identify as Deaf, Hard of Hearing or Deaf-Blind? ☐ Y ☐ N

If yes, what is the best way to communicate: *(MHST will book Interpreter)*

Spoken Language Interpreter Required? ☐ Y ☐ N If yes, language: *(MHST will book Interpreter)*

Alternate contact (if applicable): Phone Number:

Relationship: Language:

Reason for Referral

☐ Support in accessing resources	☐ Financial Stress	☐ Anxiety
☐ Grief & loss	☐ Family, relationship, or parenting stress	☐ New immigrant/refugee support
☐ Substance Use	☐ Victim services/domestic stress	☐ Advanced Care Planning
☐ Caregiver stress	☐ Depression	☐ Housing

☐ Other:_____

_____

Mental Health History

Please describe any relevant psychiatric and/or medical symptoms of concern, current diagnoses and list any relevant screening completed (i.e. PH-Q9, GAD-7, co-morbid psychiatric dx, substance abuse):

Risk Factors:
Include any risk assessments, aggression, behavioural, falls, harm to self, suicidal ideation:

PHYSICIAN REFERRING INFORMATION

Name: Phone Number:

Email Address: Fax Number:

Please complete the form and fax it to 604-699-9732

Hours of Operation: 8:00-6:00 Mon-Sat excluding statutory holidays.