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Developmental Disabilities Mental Health Services

Youth Referral Form

REFERRER DETAILS:	
Name of Referral Source & Agency:	Referral Date:
	Phone:
Relationship to the Client:	Fax/Email:

CLIENT INFORMATION:		
Surname:	Given Name(s):	Preferred Name:
Personal Health Number (PHN):	☐ Female ☐ Male ☐ Other/Unknown	DOB: (dd/mm/yy)
Address (include postal code):		Primary Phone:
Email Address:		Alternate Phone:
Primary Language:		Translator Required: ☐ Yes ☐ No

SUPPORT NETWORK:			
Primary Contact:	Relationship: (role, agency)	Phone:	Alternate: (email/phone)
Next of Kin: ☐ Same as above	Relationship:	Phone:	Alternate: (email/phone)
Primary Health Care Provider (GP/NP): (if different than referrer)		Phone:	Fax:
Specialist Involvement: (i.e. psychiatrist, neurology, metabolic etc)		Phone:	Fax:
Other Service Providers: (i.e. day program, behavioural, counselor, agency, PGT)		Phone:	Fax:
CYSN Contact Name:	Email:	Phone:	Fax:
MCFD Guardianship Social Worker:	Email:	Phone:	Fax:
School & Program Name:	Teacher/Contact Name:	Email:	Phone:
LEGAL DECISION MAKING: (*Please attach a copy of the legal documentation, if applicable)			
Legal Guardian:	Relationship:	Phone:	Alternate Contact:

REFERRAL DETAILS *(Please attach any available history or assessments)

Presenting Problems: (Please describe the current symptoms of mental illness. Include substance use, suicide risk, and risk of aggression)

Services Requested/Desired Outcome:

Current Concerns (within past 3 months):

	Yes	No	Unsure		Yes	No	Unsure
Disturbed Sleep				Behaviour Changes			
Appetite Changes				Verbal Aggression			
Mood Changes				Physical Aggression			
Suicidal Thoughts				Self-Harm			
Psychosis				Frequent Hospitalizations			
Change in Energy				Change in Concentration			
Safety Issues				Medication Side Effect			
Alcohol/Drug Use				Other:			

FOR REFERRING PHYSICIANS, NURSE PRACITIONERS, & HOSPITAL USE ONLY

If client is in hospital, actual or expected discharge date: (dd/mm/yy)

Current Medications: (including over the counter, herbals, and vitamins)

Medication Adherence: ☐ Not an issue ☐ Unknown ☐ Compliance Issues (please specify)

Medical Conditions (including allergies):

Please complete and attach current (within 3 months)

Lab Results:
- ☐ Liver function
- ☐ Kidney function (GFR)
- ☐ CBC & Electrolytes
- ☐ Thyroid (TSH)
- ☐ B12
- ☐ Ferritin
- ☐ Fasting Blood Sugar
- ☐ Lipid Panel
- ☐ Therapeutic Drug Levels
- ☐ Hormone Levels (For women over 30, if concerns)

Please attach the following reports: (if available)

Imaging Reports:
- ☐ CT Head
- ☐ EEG
- ☐ ECG
- ☐ MRI Head

Relevant Consultations:
- ☐ Neurology
- ☐ Psychiatric / Mental Health
- ☐ Psychology
- ☐ Other Medical

Doctor/NP Name:
(print or stamp):

MSP Number:

Signature:

Send Completed Referrals to:

L50 – 4946 Canada Way, Burnaby, BC, V5G 4H7 TEL: (604) 918-7540 FAX: (604) 918-7550	Burnaby, New Westminster, Tri-Cities, Maple Ridge, Vancouver, Richmond, North Shore to Pemberton & the Sunshine Coast
#207 – 2248 Elgin Ave, Port Coquitlam, BC, V3C 2B2 TEL: (604) 777-8475 FAX: (604) 461-2189	Abbotsford, Agassiz, Chilliwack, Hope, Mission, Langley Delta, Surrey, White Rock, Tsawwassen, Ladner, Aldergrove

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Who Can Refer?

Youth referrals must come through Child and Youth with Special Needs (CYSN) through the Ministry of Children and Family Development (MCFD).

Mandate:

The mandate of Developmental Disabilities Mental Health Services is to provide short-term specialized mental health services for individuals who live with co-existing developmental disabilities and a mental illness, and/ or challenging behaviors.

Instructions for Completing this Referral:

Please complete pages 1 and 2 of the referral form in full, and print clearly. An incomplete referral may result in a delays to the client being seen.

To ensure timely processing, please FAX the completed referral form (pages 1 and 2) and all supporting information to the correct office (listed on page 2 of the referral form).

Please note: DDMHS is a specialized team, and our screening and intake process is thorough. This may take time, as we collect the necessary information related to the referral.

The client and/or primary contact person will be contacted directly to discuss eligibility and service needs. Both the primary care health provider and client will be notified directly of the outcome of this referral.

Eligibility Criteria:

☐ Must have a diagnosis of developmental disability (DSM criteria) with an IQ under 70. Previous Psychological or Psycho-educational Assessment, which indicates the clients FSIQ may be required (*see note below).
☐ Client is 12 to 18 years of age.
☐ Confirmed or suspected mental illness and/or challenging behaviours requiring treatment.
☐ Client is requiring a consultation and/or assessment.

*Please Note: A psychological assessment is not required for the purpose of establishing eligibility, however, psychological assessments provide valuable information and better inform the assessment and treatment process. Please send a copy, if available.

The following referrals will not be accepted:

☐ Client is not experiencing an exacerbation of mental health symptoms and/or behavioural concerns.
☐ Clients seeking counselling as their only resource.
☐ Client seeking residential, vocational, or life skills supports (Refer to CYSN/MCFD).
☐ Clients seeking Autism or Fetal Alcohol Spectrum Disorder diagnosis.
☐ Clients seeking a Psychological or Psycho-Educational Assessment.
☐ Clients in remission seeking long term monitoring.

Please note: In accordance with Section 34 of B.C.'s Freedom of information and Protection of Privacy Act (FIPPA), this information is being requested in order to provide direct care and services, and as such, written and signed consent may not be required.