Developmental Disabilities Mental Health Services (DDMHS)

Powell River Referral Instructions

Welcome to Developmental Disabilities Mental Health Team! We are a regional mental health team that provides short-term and consultative specialized mental health support for people who live with both intellectual disabilities and mental health concerns and/or challenging behaviours. We appreciate your interest in referring someone to our services. Below are the instructions for completing and submitting our Powell River referral forms.

Purpose: This form is used to refer someone to our mental health services to see a psychiatrist.

1.
A: Adult Referral Form (ages 19+)

Who can fill this out: Powell River Referrals must come through Community Living British Columbia (CLBC).

B: Youth Referral Form (ages 12-18)

Who can fill this out: Child and Youth with Support Needs (CYSN) Social Workers (SWs) through the Ministry of Child and Family Development (MCFD) should fill out this form.

2. Primary Care Provider Form (required for all referrals)

Who can fill this out: Medical professionals (e.g., family doctors, nurse practitioners, walk in clinics)

Purpose: This form is specifically for medical professionals to refer individuals for mental health services, ensuring that any medical conditions that might mimic or influence mental health symptoms are ruled out.

Steps to Complete Forms 1 & 2. Fill out all required sections of the form. If available, please include a copy of:

- Recent hospital visit or admissions, including specialist consultation/reports
- Psychoeducational or psychological reports
- Representation Agreements or Committeeship Documents
- Other clinical reports (i.e. SLP, OT, Behavioural Plans, Safety Plans, etc.)
- Current medications and recent changes
- Reason for referral and goals for DDMHS involvement

Submit the completed forms to us via fax or deliver it to our office. Both forms are required to be seen by our psychiatrist. By following these instructions, you help us ensure that each referral is handled smoothly and on time, so we can provide the best possible care.

The following referrals will not be accepted (not eligible):
Person is not experiencing a worsening of mental health symptoms.
Person is seeking long term monitoring only.
Person is seeking counselling or behavioural therapy as their only service need.
Person is seeking residential, vocational, or life skills supports (Refer to CLBC or MCFD).
Person does not have a diagnosed intellectual disability, and is seeking a Psychological Assessment for diagnosis of an intellectual disability.

Please note: DDMHS is a specialized team, and our screening process is detailed. This can take time because we need to gather a lot of information related to the referral.

The client and/or primary contact person will be contacted directly to discuss eligibility and service needs. The referral source, family, client, and Primary Care Provider will be notified directly of the outcome of this referral.

If accepted, once treatment is complete, clients will be *discharged back to their Primary Care Provider* (NP/GP).

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Please note, Powell River referrals must go through CYSN or CLBC only

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

CLIENT INFORMATION (from BC Services Card):		
Legal Surname:	Legal Given Name(s):	Preferred Name(s):
Pronouns:	Gender:	Date of Birth: (dd/mm/yy)
Personal Health Number (PHN):	Client's Primary Language:	Translator Required: ☐ Yes ☐ No
Client Address (include postal code):		
Client Email Address:		Client Phone:
Does client wish to identify as an Indigenous person? ☐ Yes ☐ No		

SUPPORT NETWORK:			
Primary Contact:	Relationship: (role, agency)	Phone: Email:	
Next of Kin: ☐ Same as above	Relationship:	Phone: Email:	
Primary Health Care Provider (GP/NP/Pediatrician): ***MUST have a Primary Care Provider Referral form submitted***		Phone:	Fax:
Specialist Involvement: (i.e. psychiatrist, neurology, metabolic, etc.)		Phone:	Fax:
Other Service Providers: (i.e. behavioral, counselor, agency, PGT)		Phone:	Fax:
Pharmacy (Name & Location):		Phone:	Fax:
CLBC Facilitator / MCFD CYSN SW:		Phone: Email:	
Day Program / CI Worker / Support Worker:		Phone: Email:	
Speech-Language Pathologist (SLP) or Occupational Therapist (OT):		Phone: Email:	
School & Program Name:	Teacher/Contact Name:	Email:	Phone:

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/Hopes & Expectations:

Current Concerns (within past 3 months):

	Yes	No	Unsure		Yes	No	Unsure
Disturbed Sleep				Sexually Inappropriate Behavior			
Appetite Changes				Verbal Aggression			
Mood Changes				Physical Aggression			
Suicidal Thoughts				Self-Harm			
Psychosis				Frequent Hospitalizations			
Change in Energy				Change in Concentration			
Homicidal Thoughts				Medication Side Effect			
Alcohol/Drug Use				Other (specify):			

MEDICAL LEGAL DECISION MAKING: (*Please attach a copy of legal documentation, if applicable)

Youth (12-18 years):

Legal Guardian:	Relationship:	Phone:	Email:
Guardian's Primary Language:		Translator Required: ☐ Yes ☐ No	

Adults:

Is the client aware of this referral? ☐ Yes ☐ No	Is the family aware of this referral? ☐ Yes ☐ No

Is there a Substitute Decision Maker, Representative, or Committee of Person who makes health care decisions on behalf of the client? ☐ Yes ☐ Unsure ☐ No (client is their own decision maker)

If Yes, Name of Decision Maker:	Relationship:	Phone:	Alternate Contact:

Send Completed Referrals to:

Youth Referrals: Ministry of Children & Family Development, CYSN - 6944 Alberni Street, Powell River, BC V3A 2C1
TEL: (604) 485.0603 FAX: (604) 485.5498

Adult Referrals: Community Living British Columbia - Suite 205 – 6975 Alberni Street, Powell River, BC V8A 2B8
TEL: 1.877.592.1903 FAX: (604) 485.0632