Developmental Disabilities Mental Health Services (DDMHS)

Youth Referral Instructions

Welcome to Developmental Disabilities Mental Health Team! We are a regional mental health team that provides short-term, 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 referral forms.

1. Youth Referral Form (ages 12-18)

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

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

2. Primary Care Provider Form

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 someone for mental health services. It helps make sure that any medical issues that could look like, or affect, mental health symptoms are checked and 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 by fax or deliver it to our office. Both forms are required to be seen by our psychiatrist. By following these steps, 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 (Connect with MCFD).
Person is seeking a Psychological Assessment for diagnosis of an intellectual disability.

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

The client and/or main contact person will be contacted directly to talk about 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 finished, clients will be *discharged back to their Primary Care Provider* (NP/GP).

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Youth Referral Form

All youth referrals must come through MCFD's CYSN Social Workers only

MCFD / CYSN SW Information:	
Name & Position: Referral Date: _____	Phone: Fax: 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 Nurse (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:
Pharmacy (Name & Location):		Phone:	Fax:
Other Service Providers: (i.e. behavioural, counselor, agency, social work)		Phone:	Fax:
School & Program Name:	Teacher/Contact Name:	Email:	Phone:

REFERRAL DETAILS *(Please attach any available history or psychometric / psychological 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 Behaviour			
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)

Legal Guardian:	Relationship:	Phone:	Email:
Guardian's Primary Language:		Translator Required: ☐ Yes ☐ No	
MCFD Guardianship Social Worker:	Phone:	Email:	Fax:

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
9634 King George Blvd, **Surrey**, BC, V3T 0G7 TEL: (604) 777-8475 FAX: (604) 461-2189	Abbotsford, Agassiz, Chilliwack, Hope, Mission, Langley Delta, Surrey, White Rock, Tsawwassen, Ladner, Aldergrove