Djavad Mowafaghian
CENTRE FOR BRAIN HEALTH

UBC Mood Disorders Centre
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Vancouver CoastalHealth
Promoting wellness. Ensuring care

PSYCHIATRIC OUTPATIENT SERVICES – REFERRAL FORM

(*) rTMS Research

1 **Complete this entire form (3 pages)**

We accept referrals:

- ☑ for patients with mood disorders (depressive disorders, and bipolar/related disorders)
- ☑ from family physicians and nurse practitioners in the VCH catchment area: Vancouver, Richmond, North and West Vancouver, Sunshine Coast
- ☑ from psychiatrists practicing anywhere in B.C.
- ☑ for patients with recurrent seasonal depression located anywhere in B.C.

*We **DO NOT** accept referrals:*

IGNORE FOR RESEARCH

- ☒ for patients who have seen a psychiatrist in the past 6 months, unless the psychiatrist sends the referral to us
- ☒ for patients who have attended or been referred to the Psychiatric Urgent Care Program at Mood Disorders Association of BC in the past 6 months, unless the psychiatrist sends the referral to us
- ☒ for ongoing care and follow-up
- ☒ for medicolegal, forensic, or disability evaluations (including WorkSafeBC, ICBC, etc.)
- ☒ for inpatient admissions
- ☒ for group therapy
- ☒ for patients with acute suicidality, or active alcohol/substance abuse

We may suggest another service or provider that is more suitable for your patient.

2 **Enclose previous psychiatric reports, chart/consult notes, and other relevant documents**
Psychiatrists requesting a second opinion must send consultation notes.

IGNORE

3 **Detach page 3 and give it to your patient**

4 **Fax the completed form (2 pages) to**
604-827-0530

Date of Referral:	
➢ **Patient Information**	
Last name:	
First and middle names:	
Date of birth (d/m/y):	
Gender:	
Personal Health Number:	
Address:	
City/Province:	
Postal Code:	
Primary phone number:	
Alternate phone number:	
Occupation:	
Employer:	
➢ **Next of Kin**	
Name:	
Relationship:	
Address:	
City/Province:	
Postal Code:	
➢ **Referral Source**	
❑ Psychiatrist	❑ Family Physician
❑ Nurse Practitioner	❑ Other:
Name:	
Billing number:	
Address:	
City/Province:	
Phone number:	
Fax number:	

❑ I have discussed this referral with the patient and given the letter on page 3.

_____
Signature of referring physician/psychiatrist

Patient's Name (Last, First):

➢ **Has your patient attended our clinic before?**

❑ No ❑ Yes

➢ **Are there any other mental health referrals pending?**

❑ No ❑ Yes

If yes, list:

➢ **Primary diagnosis:**

❑ Bipolar I Disorder

❑ Bipolar II Disorder

❑ Other Bipolar/Related Disorder (specify):

❑ Major Depressive Disorder

❑ Persistent Depressive Disorder (Dysthymia)

❑ Other Depressive Disorder (specify):

❑ Uncertain/unknown at this time

Current date of onset:

➢ **Other psychiatric diagnoses (specify):**

➢ **Any substance abuse/use within the past two months?**

❑ No ❑ Yes

➢ **Any past contact with mental health services?**

❑ No ❑ Remote/unknown ❑ Yes

If yes (specify names):

Consults/records must be included with this referral

➢ **List current mental health supports:**

➢ **Why does your patient need an assessment now?**
List current problems/symptoms:

➢ **What do you want from this assessment?**

❑ Diagnostic clarification

❑ Second opinion requested by psychiatrist

❑ Treatment recommendations

❑ Other (specify):

➢ **Comorbid medical issues:**

➢ **Recent labs?**

❑ No ❑ Yes (include with referral)

➢ **Current medications (including psychiatric)**

Drug name	Dose

➢ **Past psychiatric medications/treatments**

Drug/treatment name	Dose

For clinic use only: Referral is ❑ Accepted ❑ Deferred ❑ Declined Comments:
Appt. with Dr. **Date and time:**

❑ Confirmed with patient ❑ Package sent ❑ Reminder call given