



PATIENT IDENTIFICATION

Patient Name: (include alias)
Date of Birth: Year/Month/Day
Patient/Address:
PHN

REFERRAL DATE

- SERVICE REQUESTED
ADULT PSYCHIATRY
Psychiatric Intensive Care Unit
Refractory Psychosis Unit
Acute/Intermediate Assessment & Treatment
GERIATRIC PSYCHIATRY

CURRENT CARE PROVIDERS

Referring Agency Phone
Admission Date to Referring Hospital
Referring Physician Name, Signature & Phone
M.H.C./Community Care Team Involved Case Manager
Involved Family Contact Family Physician Phone Number Name & Phone

- REASON(S) FOR REFERRAL: Acute/Intermediate Assessment & Treatment
Pharmacological Review/Treatment Trials
Diagnostic Clarification
Behavioral Assessment/ Management

Voluntary Certified Under Mental Health Act Date certification will expire

Diagnosis (DSM Axis I to V):

Axis I:
Axis II:
Axis III:
Axis IV:
Axis V:

RIVERVIEW HOSPITAL
PATIENT FUNCTIONAL ASSESSMENT: please check appropriate boxes

Current behavioural risks/ aggression/violence: **Self** - Yes No **Caregivers** - Yes No **Others** - Yes No

AWOL risk: Yes No

Use of PRN in the past 48 hrs None Once More than 3 times More than 5 times

Forensic Involvement:

criminal record No Yes forensic history No Yes current charges No Yes **(describe)**

History of violence - No Yes **(describe)** _____

Cognition: disoriented confused intact

Mood: irritable/hostile agitated/anxious depressed elated labile normal

Psychosis: delusions - No Yes **(describe)** _____

hallucinations - No Yes **(describe)** _____

thought form disorder - No Yes

Any sexually disinhibited behaviours? No Yes **(describe)** _____

Level of nursing attention: general supervised special attention (q 15 mins)

1:1/ constant – reason _____

Seclusion: No Yes - Date last used: _____ Time in seclusion _____

Mechanical Restraint: No Yes **(describe)** _____

Check if secure care required because of: elopement risk drug seeking behaviour other **(describe)** _____

Language barriers: needs interpreter – language _____
 hard of hearing

Ambulation: walks without assistance walks with assistance
 unsteady wheelchair/walker

Sleep: no insomnia mild insomnia awakes frequently

ADL: independent needs prompts needs assistance

Eating: normal anorexic needs assistance
 nasogastric tube feeding gastrostomy

Infectious disease status: antibiotic resistant organisms HIV +ve HEP B +ve
(if known) HEP C +ve TB status Other (describe) _____

Medications: compliant non compliant antibiotics
 requires I/V medications

CURRENT VITAL SIGNS: T. P. R. B/P Weight

CURRENT PSYCHIATRIC CONCERNS:

CURRENT SUBSTANCE ABUSE AND CONCERN:

CURRENT MEDICAL/PHYSICAL CONDITION: (include ongoing conditions/illnesses):

Completed by:

Name of Physician (*please print*) _____

Signature of Physician _____ Contact number _____

Date: _____

RIVERVIEW HOSPITAL REQUIRED DOCUMENTATION:

Please note: Documentation must be received for the referral to be processed.

Please FAX to: 604-524-7562

- Hospital Admission Separation Sheet or Facility/Boarding home face sheet
 - Initial Psychiatric Consultation/Assessment (current stay)
 - Current psychiatric Progress Notes or Physicians summary of this admission
 - Current Physical Examination and current physical status (include allergies, recent illnesses)(summary)
 - Completed RVH Patient Functional Assessment (see attached)
 - Current medications (MAR), medication profile if available
 - Specialist consultations, second opinions
 - Current lab work, results of CT/MRI scans, other diagnostic imaging, EEGs, Xrays or indicate if results are pending
 - Social Work Notes or summary on this admission
 - Written Discharge Commitment
 - Available past psychiatric history (ie. Mental Health Team notes)
 - Involuntary Status - send forms 4, 5, 6, 15, 20
 - Review panel pending - No Yes **(Scheduled date)** _____
 - ECT records of current treatments (if applicable) **(Details)** _____
- Past ECT treatments - No Yes

ADDITIONAL PROGRAM SPECIFIC REQUIREMENTS:

ADULT:

PSYCHIATRIC INTENSIVE CARE UNIT:

- All Doctors orders for this admission
- Admissions/Discharge Summaries/face sheet from last 2 admissions, if available

REFRACTORY PSYCHOSIS UNIT:

- Historical Medication report last 1 – 5 years

GERIATRICS:

- Urinalysis
- Advance Directives, if available