BC Mental Health & Addiction Services
An agency of the Provincial Health Services Authority

REFERRAL FOR ADMISSION TO RIVERVIEW HOSPITAL

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: ____
____
____

Avis V: ____
____
____

PATIENT FUNCTIONAL ASSESSMENT: please check appropriate boxes

Current behavioural risks/ aggregation/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 ☐ antibotics
☐ 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