

DATE: \_\_\_\_\_

PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Patient Address: \_\_\_\_\_ PHN: \_\_\_\_\_  
 Main Contact #: \_\_\_\_\_

MHWC EXCLUSION CRITERIA	1. Primary substance abuse/primary psychosis	3. Medical-legal assessments
	2. Significant risk of physical aggression	4. Address outside City of Vancouver

COMMUNITY REFERRALS ONLY:	HOSPITAL REFERRALS ONLY:
<input type="checkbox"/> <b>SHARED CARE</b> Family practice physicians seeking a <b>one-time consult</b> for diagnostic clarification, medication and treatment recommendations.	<input type="checkbox"/> <b>ACUTE PSYCHIATRIC ASSESSMENT CLINIC (APAC)</b> SPH/MSJ Emergency (ER), Consult Liaison (CL) and SPH Inpatient Unit referrals seeking short term treatment (1 to 10) sessions <b>for anxiety/depression and mood disorders</b>
<input type="checkbox"/> <b>OUTPATIENT PSYCHIATRIC ASSESSMENT CLINIC (OPAC)</b> Family practice physicians seeking short term treatment (1 to 10) sessions <b>for anxiety/depression and mood disorders</b>	
<input type="checkbox"/> <b>REPRODUCTIVE PSYCHIATRY</b> Women who are pregnant or within 12 months post-partum. Services for pregnancy planning, pregnancy loss, infertility and PMS/PMDD. This program has a large geographical catchment area if not within this area the referral physician will be notified with resource options Pregnant EDC: _____ <input type="checkbox"/> Pregnancy Planning Postpartum Delivery Date: _____ <input type="checkbox"/> Pregnancy Loss <input type="checkbox"/> Infertility <input type="checkbox"/> PMS/PMDD <input type="checkbox"/> Risk of harm to self or baby	
<input type="checkbox"/> <b>GROUP THERAPY</b> Intake decisions are made by a team of psychologists and psychiatrist	<input type="checkbox"/> <b>MHWC ELECTRO-CONVULSIVE TREATMENT (ECT)</b> Inpatients with significant depression history, particularly those not responding to antidepressants, have severe depression or are at a high risk for suicide who are now being discharged and require outpatient ECT sessions.  REFERRING RESIDENT/PSYCHIATRIST:  _____ Printed name

Presenting concern(s): \_\_\_\_\_

ATTACH A CLINICAL SUMMARY and other relevant assessment information. Patient must be agreeable to referral and aware we are a teaching hospital with residents and medical students working with the psychiatrists.

COMMUNITY REFERRING PHYSICIAN/CLINICIAN

**I hereby commit to follow this patient in the community:**

Printed name: \_\_\_\_\_

Phone: \_\_\_\_\_

Billing ID: \_\_\_\_\_ Fax: \_\_\_\_\_

Signature/stamp of referring Physician

**Fax completed referral and relevant information to:  
MHWC at 604-806-8287**

For more information, visit our website

<http://mh.providencehealthcare.org/> or contact our clinic at **604-806-8004.**

