INNER CITY YOUTH PROGRAM

REFERRAL

Phone: 604-806-9415
Email: ICYMHP@providencehealth.bc.ca

SERVICES AVAILABLE:

☐ **Intensive Case Management**	• 16 to 24 years old • Requires intensive outreach/unable to engage in traditional mental health and/or substance use services • Confirmed or suspected mental health diagnosis and/or substance use
☐ **Shared Care/ Psychiatric Consult**	• 12 to 24 years old • Referral by MD/NP required
☐ **Primary Care**	• 12 to 24 years old • Family practice/general practice for physical health
☐ **Counselling**	• 12 to 24 years old • Short term counselling including mental health and substance use services

REFERRAL SOURCE

Referral person: _____ Agency/Program: _____

Referring date: _____ Phone #: _____

PATIENT INFORMATION

Patient's legal name:

Gender on Legal ID: ☐ Male ☐ Female

Patient's preferred name:

DOB: (mm/dd/yy)

Gender: _____

Patient's address (If NFA , where can we find this patient):

_____

☐ Home ☐ Shelter ☐ Other: _____

PHN or Provincial Insurance Program #: _____

Phone No: _____ Email address: _____

If patient has no phone, contact: _____
Name Phone No.

Is patient currently hospitalized? ☐ Yes ☐ No

If YES, anticipated date of discharge: _____ Which hospital/unit? _____

HISTORY

Family physician/Nurse practitioner: Billing #:

Current mental health symptoms/concerns:

Current physical health symptoms/concerns:

Continued on page 2

INNER CITY YOUTH PROGRAM

REFERRAL

Phone: 604-806-9415
Email: ICYMHP@providencehealth.bc.ca

HISTORY (continued)		
Previous diagnoses: (including diagnosing doctor, year)		
Previous mental health care: (assessments/treatments, include copies if available)		
ER visits/hospitalization history:		
Current medications:		
Intellectual disability: (specify if confirmed or suspected)		
Current substances used:	History of problematic substance use:	Previous substance use treatment:
List any involved service providers: (e.g. Covenant House, DCHC, Directions, UNYA, MCFD etc.)		

Patient consent is REQUIRED if referral source is not a healthcare provider.

Patient signature: _____ Date: _____

Signature of referring person: _____ Date: _____

Fax completed Referral, Consent for Release of Information,
and copies of all relevant information to the

INNER CITY YOUTH PROGRAM: 604-297-9671