

INNER CITY YOUTH PROGRAM REFERRAL

Phone: 604-806-9415

Email: ICYMHP@providencehealth.bc.ca

SERVICES AVAILABLE:

<input type="checkbox"/> Intensive Case Management	<ul style="list-style-type: none"> • 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
<input type="checkbox"/> Shared Care/ Psychiatric Consult	<ul style="list-style-type: none"> • 12 to 24 years old • Referral by MD/NP required
<input type="checkbox"/> Primary Care	<ul style="list-style-type: none"> • 12 to 24 years old • Family practice/general practice for physical health
<input type="checkbox"/> Counselling	<ul style="list-style-type: none"> • 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: <input type="checkbox"/> Male <input type="checkbox"/> Female
Patient's preferred name: _____	DOB: (mm/dd/yy) _____	Gender: _____
Patient's address (If NFA , where can we find this patient): _____ <input type="checkbox"/> Home <input type="checkbox"/> Shelter <input type="checkbox"/> Other: _____		PHN or Provincial Insurance Program #: _____
Phone No: _____ Email address: _____		
If patient has no phone, contact: _____ Name Phone No.		
Is patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____ _____	

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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***