Interior Health

ADOLESCENT PSYCHIATRY UNIT INTAKE REFERRAL FORM

Kelowna General Hospital
2268 Pandosy Street
Kelowna, BC V1Y 1T2
TEL 250-862-4346
FAX 250-862-4347

This form must be completed by a physician or clinician.

Urgent Referral

Attending Psychiatrist can contact the APU at 250-862-4346 to discuss a potential referral to the unit.

Youth who are currently admitted to a hospital and require urgent service:

- Age 12 – 17
- Resident of Interior Health region
- Assessed by Psychiatrist at referring Hospital
- Experiencing major mental illness
- Severe and persistent safety concerns
- Medically stable

Youth with a primary concern of eating disorder, conduct disorder, developmental disorder or substance use, will not be accepted to the APU. For youth with these concerns consider BC Children's Hospital, Maples Treatment Program, or Addiction Services.

Planned Admissions

Youth who require an in-patient, multi-disciplinary, tertiary mental health assessment and treatment planning service. Upon admission clients must have a secure living arrangement and a community clinician in place. Referrals are reviewed weekly.

- Age 12 – 17
- Resident of Interior Health region
- Significant psychiatric symptoms beyond the assessment or treatment scope of community resources
- Has completed a recent psychiatrist assessment where available

Youth with a primary concern of eating disorder, conduct disorder, developmental disorder, substance use, will not be accepted to the APU. For youth with these concerns consider BC Children's Hospital, Maples Treatment Program, or Addiction Services

Referring Organization / Hospital Unit	Referral Date	Tel	
Contact	Email	Fax	
Youth's Name	Date of Birth	Gender	
Address		Email	
Living with ☐ Parents ☐ Foster Parents / Group Home ☐ Other			
Legal Status ☐ Parental Guardianship ☐ Temporary Ward ☐ Custody: Joint / Individual ☐ Continuing Care Ward ☐ Parents Separated ☐ In Care By Agreement		Family aware of referral? ☐ Yes ☐ No	
Social Worker	Email	Tel	
Mother's Name	Email	Cell	Home
Father's Name	Email	Cell	Home
Caregiver Name *(if not parents)*	Email	Cell	Home
School Name		☐ Regular ☐ Alternate ☐ Home School	
Counsellor Name		Grade Attending ☐ Yes ☐ No	

Current / Past Charges with RCMP	☐ No	☐ Yes. Details	
Pending Charges with RCMP	☐ No	☐ Yes. Details	
Convictions	☐ No	☐ Yes. Details	
Extrajudicial Sanctions	☐ No	☐ Yes. Details	

Fax completed referral form and relevant reports to 250-862-4347

Clear Form Print Form

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Seen by Psychiatrist ☐ Yes ☐ No ☐ Not available ☐ On waitlist (Local or Outreach)		
Name of Psychiatrist	Last seen	Next appointment
Seen by Pediatrician / GP ☐ Yes ☐ No		
Name of Pediatrician / GP	Last seen	Next appointment
Details of any significant medical concerns		
C & Y Mental Health Clinician ☐ Yes ☐ No ☐ Not available ☐ On waitlist; estimated wait time		
Name	Last seen	Next appointment
Email	Tel	Fax
Other Community Services	Tel	Email

Presenting Concerns	☐ Attention Problems	☐ Depressed Mood	☐ Suicidal Ideation	☐ Self-Harming Behaviour, Non-suicidal	☐ Drug Misuse
	☐ Alcohol Misuse	☐ Anti-Social Behaviour	☐ Family Issues		☐ Academic Difficulties
	☐ Hyperactivity	☐ Excessive Anxiety	☐ Attempting Suicide		☐ Other

Description	
Impression	

Reasons for Referral	☐ Assessment
	☐ Diagnostic clarification
	☐ Medication review
	☐ Medication change
	☐ Stabilization of symptoms
	☐ Treatment planning
	☐ Other *(please specify)*
Currently Certified Under the Mental Health Act? ☐ Yes ☐ No	

Medication	☐ Current ☐ Prior	Dosage	Duration
	☐ Current ☐ Prior	Dosage	Duration
	☐ Current ☐ Prior	Dosage	Duration
	☐ Current ☐ Prior	Dosage	Duration
	☐ Current ☐ Prior	Dosage	Duration
	☐ Current ☐ Prior	Dosage	Duration
	☐ Current ☐ Prior	Dosage	Duration
	☐ Current ☐ Prior	Dosage	Duration

Relevant reports or assessments to be included
Psychiatrist Report (required) ☐ Yes ☐ No; why not?
All other Assessment Reports on file *(including psychological, medical, etc.)* ☐ Yes ☐ No; why not?
Psychosocial Assessment ☐ Yes ☐ No; why not?

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