BC Neuropsychiatry Program
UBC Hospital, Detwiller Pavilion
Vancouver, BC V6T 2B5

Phone: 604.822.9758
Fax: 604.822.7491
Web: www.bcnp.ca
Email: bcnp.admin@vch.ca

FOR BCNP REFERRALS, referral form and instructions are on the website BCNP.ca as well ("*Program Description & Referral Forms*" link on top left-hand corner).

BCNP Sites
UBC Hospital: Vancouver
Hillside Centre: Kamloops

1. **All INPATIENT referrals must be approved by your regional health authority. Please complete form and fax as indicated below:**

Fraser Health: FHA Liaison
Fax: 604-519-8548
Phone: 604-519-8597

Interior Health: IHA Liaison
Fax: 250-314-2410
Phone: 250-314-2171

Northern Health: NHA Liaison
Fax: 250-645-7983
Phone: 250-645-7449

Vancouver Island Health: VIHA Liaison
Fax: 250-737-2695
Phone: 250-737-2030 x44633

Vancouver Coastal Health: BCNP Office
Fax: 604-822-7491
Phone: 604-822-9758

2. **Please complete all required sections of the referral form and include legible contact information, including fax numbers.**

3. **NOTE ABOUT LENGTH OF STAY: Due to demands on the limited inpatient beds, in general, patients are admitted for a *2-week assessment period*. Extensions to the length of admission will depend on individual needs.**

For all other BCNP inquiries please call:
P: 604-822-9758 P: 604-822-7369
Email: bcnp.admin@vch.ca

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INPATIENT REFERRAL FORM AND CHECKLIST (March 2023)

All referrals are screened at our weekly triage meeting. Please ensure that the referral form, referral checklist and all requested information are attached. ***Incomplete referrals will be returned for completion and will delay processing of your referral.***
PLEASE PRINT LEGIBLY

Date of Referral: _____

Patient currently is an Outpatient ☐ Patient currently is an Inpatient ☐
Type of condition: Psychiatric condition with organic pathology ☐ Somatic/Somatoform Disorder ☐

Diagnosis and goal(s) of referral: _____
_____

PATIENT INFORMATION: PHN: _____

Surname: _____ First Name:_____ Sex: M ☐ F ☐

Address_____ City: _____ PC: _____

Telephone number: (Home) _____ (Cell): _____

Date of Birth: DD/MM/YYYY _____ Age: _____

REFERRING PHYSICIAN: Family Physician ☐ Psychiatrist ☐ Neurologist ☐ Other: _____

Referring physician name: _____ Billing number: _____

Address: _____

Phone: _____ Fax:_____ Private line:_____

Doctor's Office Administrative Email/Office Contact Email: _____

Family physician_____ Phone: _____ Fax:_____

Treating psychiatrist_____ Phone: _____ Fax:_____
Does the treating psychiatrist support the referral? Yes ☐ No ☐

Treating neurologist_____ Phone: _____ Fax:_____

Mental health team_____ Phone:_____ Fax:_____

Mental Health Team contact / case manager: _____

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REFERRAL FORM CHECKLIST

(must be completed)

Referral checklist for_____
Patient/Client Name

1. Acceptance criteria reviewed and patient meets acceptance criteria ☐
2. No active substance use disorder ☐
3. >18 years and < 75 years ☐
4. No active litigation (Worksafe, ICBC) ☐
5. Referral form completed ☐
6. Initial and most recent psychiatric consultation reports attached ☐
7. Initial and most recent neurological consultation reports attached ☐

** **NOTE:** If results are pending, please await results before sending referral. **

8. CT scans reports attached ☐ never done ☐
9. MRI scans reports attached ☐ never done ☐
10. SPECT scans reports attached ☐ never done ☐
11. EEG reports attached ☐ never done ☐
12. Lumbar puncture report attached ☐ never done ☐
13. Most recent laboratory tests attached ☐
14. For patients with neurocognitive issues:
    Recent MOCA completed and attached ☐
15. Neurobehavioral Inventory (NBI-R) attached completed and attached ☐
16. For current inpatients:

    Hospital:_____ Unit:_____

    Unit phone: _____ Unit fax:_____

    Admission Date (DD/MM/YYYY):_____

    Voluntary admission ☐
    Involuntary admission send forms 4, 5, 6, 13, 15 and 20 ☐
    Current medication profile (MAR) ☐
    Nursing Care Plan ☐
    Social Work/Occupational Therapy notes on this admission ☐
    Written Discharge Commitment (attached) ☐

Name of referrer: _____

Signature: _____ Date: _____

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RE: DISCHARGE COMMITMENT/ RETURN AGREEMENT

Date: _____

In order to maintain a responsive system, we understand that discharges from the tertiary system to the referring communities will be required.

This letter is to advise that we will accept _____
(Patient/Client)

back to _____
(Hospital or Facility)

Specific Unit/Ward/Floor/Program _____

within 30 days (Hillside Centre) or 7 days (UBC Hospital) of his/her readiness for discharge from BCNP In-Patient programming.

_____
Patient Care Coordinator or Manager

Phone Number: _____

_____
Referring Psychiatrist

This form must be completed before an admission will be scheduled.

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CONSENT & DECISION MAKING

Is the Client:

Aware of the referral?	Yes☐	No ☐
Aware of the tentative discharge plan?	Yes☐	No ☐
Capable of consenting to the admission?	Yes☐	No ☐
In agreement with the referral?	Yes☐	No ☐

Is the Client's Family:

Aware of the referral?	Yes☐	No ☐
Aware of the tentative discharge plan?	Yes☐	No ☐
In agreement with the referral?	Yes☐	No ☐

Other Comments:

_____

_____

Does the patient have any of the following in place, related to health care decision making?

Representation Agreement (Healthcare):	Yes☐	No ☐
Committee of Person:	Yes☐	No ☐
Advance Care Plan or Directive:	Yes☐	No ☐

If *"YES"* to <u>any of the above,</u> please attach forms and provide details below including <u>Name and Contact Information of the Substitute Decision Maker/Committee</u>:

_____

_____

NEUROBEHAVIORAL INVENTORY - REVISED 2004 (NBI-R)

PATIENT _____ **DATE** _____ **RATER** _____

CHECK THE APPROPRIATE BOX AND CIRCLE THE APPROPRIATE SUBCATEGORY

1	**NUTRITION**	☐ **NEEDS TO BE FED**	☐ **EATS WITH ASSISTANCE**	☐ **EATS WITH PROMPTING**	☐ **EATS INDEPENDENTLY**
2	**BLADDER**	☐ **INCONTINENT**	☐ **CONTINENT IF TOILETED**	☐ **SELF-CONTINENT WITH PROMPT**	☐ **SELF-CONTINENT WITHOUT PROMPT**
3	**BOWEL**	☐ **INCONTINENT &/OR SMEARS**	☐ **CONTINENT IF TOILETED**	☐ **SELF-CONTINENT WITH PROMPT**	☐ **SELF-CONTINENT WITHOUT PROMPT**
4	**BATHING GROOMING**	☐ **NEEDS TO BE BATHED & GROOMED**	☐ **BATHES/GROOMS WITH ASSISTANCE**	☐ **BATHES/GROOMS SELF WITH PROMPT**	☐ **BATHES/GROOMS SELF - NO PROMPT**
5	**DRESSING**	☐ **NEEDS TO BE DRESSED**	☐ **DRESSES WITH ASSISTANCE**	☐ **DRESSES SELF WITH PROMPT**	☐ **DRESSES SELF WITHOUT PROMPT**
6	**MOBILITY**	☐ **BED/CHAIR BOUND**	☐ **MOBILE WITH WHEELCHAIR**	☐ **MOBILE WITH WALKING AIDS**	☐ **INDEPENDENTLY MOBILE**
7	**ORIENT**	☐ **DISORIENTED**	☐ **ORIENTED WITH WRITTEN PROMPTS**	☐ **ORIENTED WITH VERBAL PROMPTS**	☐ **ORIENTED NO PROMPTS**
8	**SPATIAL ORIENTATION**	☐ **UNABLE TO LOCATE BEDROOM**	☐ **LOCATES BEDROOM SIGN NEEDED**	☐ **LOCATES BEDROOM NO SIGN NEEDED**	☐ **LOCATES ALL ROOMS**
9	**WANDERS**	☐ **WANDERS; NEEDS LOCKED DOORS**	☐ **WANDERS; NEEDS CLOSED DOORS**	☐ **WANDERS BUT RETURNS**	☐ **NO WANDERING**
10	**SOCIAL 1:1**	☐ **MUTE & UNRESPONSIVE**	☐ **MUTE BUT RESPONSIVE**	☐ **LITTLE VERBAL OUTPUT**	☐ **VERBAL & ACCESSIBLE**
11	**SOCIAL GROUP**	☐ **ISOLATES**	☐ **PISA (XM) WITH PROMPT**	☐ **PISA (XM) WITHOUT PROMPT**	☐ **SPONTANEOUS PEOPLE SEEKING**
		PISA (XM) = participates in scheduled activities (excluding meals)			
12	**ATTENTION**	☐ **GSA 0-15 MINUTES**	☐ **GSA 15-30 MINUTES**	☐ **GSA 30-60 MINUTES**	☐ **GSA > 60 MINUTES**
		GSA = ability to sustain-goal directed activity in minutes			
13	**SCREAMING YELLING**	☐ **CONSTANTLY**	☐ **FREQUENTLY**	☐ **OCCASIONALLY**	☐ **NEVER**
14	**MOTOR RESTLESSNESS**	☐ **3/3**	☐ **2/3**	☐ **1/3**	☐ **0/3**
		a. pacing	*b. frequent changing positions*	*c. foot tapping and/or hand wringing*	
15	**DISINHIBITION**	☐ **3/3**	☐ **2/3**	☐ **1/3**	☐ **0/3**
		a. irritable, loud or silly	*b. intrusive - verbal or interpersonal space*	*c. inappropriate public habits*	
16	**APATHY**	☐ **3/3**	☐ **2/3**	☐ **1/3**	☐ **0/3**
		a. aimless/mindless lying &/or sitting for hours		*b. quiet*	*c. slow*
17	**AGGRESSIVE BEHAVIOR**	☐ **COMBATIVE UNPREDICTABLE**	☐ **COMBATIVE PREDICTABLE**	☐ **VERBALLY THREATENING**	☐ **NO INAPPROPRIATE AGGRESSION**
		Frequency of aggression:	*a. daily*	*b. 2-3 per week*	*c. 1 per week* *d. 1 per month* *e. 1 per 6 months*
		Date of most recent episode:			
18	**SEXUAL BEHAVIOR**	☐ **PUBLIC SELF PLAY/DISPLAY**	☐ **PRIVATE SELF PLAY/DISPLAY**	☐ **INAPPROPRIATE TOUCHING/REMARKS**	☐ **NO INAPPROPRIATE BEHAVIOR**
		Frequency of sexual behavior:	*a. daily*	*b. 2-3 per week*	*c. 1 per week* *d. 1 per month* *e. 1 per 6 months*
		Date of most recent episode:			
19	**COMPLIANCE ADL'S**	☐ **REFUSES TO PARTICIPATE IN ADL'S**	☐ **PIADL STRONG PROMPT**	☐ **PIADL MODERATE PROMPT**	☐ **PIADL MILD/NO PROMPT**
			PIADL = participates in activities of daily living		
20	**COMPLIANCE TREATMENT**	☐ **REFUSES**	☐ **STRONG PROMPTS**	☐ **MODERATE PROMPTS**	☐ **MILD/NO PROMPTS**