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

BCNP Sites
UBC Hospital: Vancouver
Hillside Centre: Kamloops

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

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

Forward completed package via fax or email to:

BC Neuropsychiatry Program
Fax: 604-822-7491
Email: bcnp.admin@vch.ca

Please only send faxes in batches of 50 pages or less.
Email is preferred for large volume packages over 50 pages.

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

Please be aware:

1. Due to the ongoing psychiatric care often required, availability of BCNP clinicians for patients requiring follow-ups are very limited. *Patients should already be connected to a local psychiatrist or mental health team prior to referral, who will undertake ongoing community care after assessment by the BCNP.*
2. All referrals with somatic symptom disorder / functional neurological condition must have already been assessed by the relevant specialists to strongly exclude organic pathology. ***Outpatient somatic symptom/FND referrals must come from treating psychiatrists and must include the initial assessment and most recent psychiatric consultation.***
3. As a provincial resource, we will review cases based on severity, duration, and functional disability.

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OUTPATIENT REFERRAL FORM AND CHECKLIST (October 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: _____

Current situation: ☐ Patient currently is an outpatient ☐ Patient currently is an inpatient

Type of condition: ☐ Psychiatric condition + organic pathology ☐ Somatic Symptom/ Functional

Diagnosis and goal(s) of referral: _____

_____

PATIENT INFORMATION: PHN: _____

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

Address_____ City_____ Postal Code: _____

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 (if not referring physician)? 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 ☐
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. For current inpatients: ☐

Hospital: _____ Unit:_____

Unit Phone: _____ Unit Fax:_____

Admission date (DD/MM/YYYY): _____

Anticipated discharge date (DD/MM/YYYY): _____

Name of referrer: _____

Signature: _____ Date: _____

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CONSENT & DECISION MAKING

Is the Client:

Aware of the referral? Yes ☐ No ☐

In agreement with the referral? Yes ☐ No ☐

Is the Client's Family:

Aware of the referral? 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>:

_____

_____