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 our website BCNP.ca Under the blue banner bar on the top left hand corner "*Program Description & Referral Forms*"

1. **All INPATIENT referrals must be approved by your regional health authority. NOTE: As per our discharge agreement all patients will be returned to the inpatient unit facility that they arrived from or discharged to the care of their outpatient community treating psychiatrist as per BCNP policy.**

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
E-mail: MHSUTertiaryAccess@islandhealth.ca
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
Email: bcnp.admin@vch.ca

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

INPATIENT REFERRAL FORM AND CHECKLIST (March 2024)

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: _____

BC Neuropsychiatry Program
UBC Hospital, Detwiller Pavilion
Vancouver, BC V6T 2B5
Phone: 604 822 9758 Fax: 604 822 7491

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: _____

BC Neuropsychiatry Program
UBC Hospital, Detwiller Pavilion
Vancouver, BC V6T 2B5
Phone: 604 822 9758 Fax: 604 822 7491

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.

BC Neuropsychiatry Program
UBC Hospital, Detwiller Pavilion
Vancouver, BC V6T 2B5
Phone: 604 822 9758 Fax: 604 822 7491

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

NAME DATE AGE RATER

CHECK THE APPROPRIATE BOX

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 falls risk yes ○ no ○	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