Vancouver CoastalHealth
Promoting wellness. Ensuring care.

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

**** The BC Neuropsychiatry program will only accept referrals that are made by the patient's treating psychiatrist. ****

FOR BCNP REFERRALS, referral form and instructions are on our website BCNP.ca (Under the blue bar "*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

For all other BCNP inquiries
Phone: 604-822-9758
Email: bcnp.admin@vch.ca

- **Do you agree to provide ongoing community care after assessment or hospitalization?**
  YES ☐ **NO** ☐
- **For somatic symptom disorder see program guidelines. There are specific requirements for any patient who is considered to have a somatic symptom disorder. Please request these forms from our office by calling: Phone: 604-822-7491 or emailing 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

OUTPATIENT REFERRAL FORM AND CHECKLIST (February 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 disorder due to medical condition ☐ Somatic/Somatoform Disorder ☐

Diagnosis and goal(s) of referral: _____

_____

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

PHN: _____

Address:_____ City:_____ Postal Code: _____

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

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

REFERRING PHYSICIAN: Psychiatrist ☐

Referring physician name: _____ Billing number: _____

Address: _____

Phone: _____ Fax:_____ Private line:_____

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

Family physician:_____ Phone: _____ Fax:_____

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 (ICBC, WorkSafe BC, active trial) ☐
5. Referral form completed ☐
6. Initial and most recent psychiatric consultation reports attached ☐
7. Initial and most recent neurological/medical consultation reports attached ☐

** **NOTE:** If results are pending, please defer the referral until the investigations have been completed and reports can be forwarded prior to sending the 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 ☐ never done ☐
14. For patients with **neurocognitive** issues: ☐ never done ☐
    Recent MOCA completed and attached

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

CONSENT & DECISION MAKING

Is the Patient/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>:

_____

_____

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