Providence HEALTH CARE

St. Paul's Hospital
MENTAL HEALTH WELLNESS CLINIC (MHWC) REFERRAL FORM

DATE: _____

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Patient Address: _____ PHN: _____

Main Contact #: _____

MHWC EXCLUSION CRITERIA

1. Primary substance abuse/primary psychosis
2. Significant risk of physical aggression
3. Medical-legal assessments
4. Address outside City of Vancouver

COMMUNITY REFERRALS ONLY:

☐ **SHARED CARE**

Family practice physicians seeking a **one-time consult** for diagnostic clarification, medication and treatment recommendations.

☐ **OUTPATIENT PSYCHIATRIC ASSESSMENT CLINIC (OPAC)**

Family practice physicians seeking short term treatment (1 to 10) sessions **for anxiety/depression and mood disorders**

☐ **REPRODUCTIVE PSYCHIATRY**

Women who are pregnant or within 12 months post-partum. Services for pregnancy planning, pregnancy loss, infertility and PMS/PMDD. This program has a large geographical catchment area if not within this area the referral physician will be notified with resource options

Pregnant
EDC: _____

Postpartum
Delivery Date: _____

☐ Pregnancy Planning
☐ Pregnancy Loss
☐ Infertility ☐ PMS/PMDD
☐ Risk of harm to self or baby

☐ **GROUP THERAPY**

Intake decisions are made by a team of psychologists and psychiatrist

HOSPITAL REFERRALS ONLY:

☐ **ACUTE PSYCHIATRIC ASSESSMENT CLINIC (APAC)**

SPH/MSJ Emergency (ER), Consult Liaison (CL) and SPH Inpatient Unit referrals seeking short term treatment (1 to 10) sessions **for anxiety/ depression and mood disorders**

☐ **MHWC ELECTRO-CONVULSIVE TREATMENT (ECT)**

Inpatients with significant depression history, particularly those not responding to antidepressants, have severe depression or are at a high risk for suicide who are now being discharged and require outpatient ECT sessions.

REFERRING RESIDENT/PSYCHIATRIST:

_____
Printed name

Presenting concern(s): _____

_____

_____

ATTACH A CLINICAL SUMMARY and other relevant assessment information. Patient must be agreeable to referral and aware we are a teaching hospital with residents and medical students working with the psychiatrists.

COMMUNITY REFERRING PHYSICIAN/CLINICIAN

I hereby commit to follow this patient in the community:

Printed name: _____

Phone: _____

Billing ID: _____ Fax: _____ **Signature/stamp of referring Physician**

Fax completed referral and relevant information to:
MHWC at 604-806-8287

For more information, visit our website
http://mh.providencehealthcare.org/ or contact our clinic at 604-806-8004.