First Nations Virtual Substance Use and Psychiatry Services
Referral Form

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Psychiatry Referral Form

The First Nations Virtual Substance Use and Psychiatry Service (FNvSUPS) provides Indigenous people and their families living in BC with **NON-URGENT** access to specialists in Addictions Medicine and Psychiatry and Mental Health and Wellness Care Coordinators. This is the referral for the psychiatry service.

This is a **REFERRAL-BASED** service. We accept referrals from physicians and other mental health workers. It is available at no cost to Indigenous people and their family members, even if those family members are not Indigenous. We are dedicated to the principles and practices of **cultural safety and humility,** and to delivering trauma-informed care. ***This is NOT an urgent service as there may be a significant wait to see a specialist. For immediate assistance, call 911 or visit the emergency room at the nearest hospital.***

Please note that this service does not accept forensic referrals and does not provide third-party reports to courts, government, or insurance companies.

Services are Monday-Friday 9:30AM - 3:00PM. Consultation by Zoom video **only.**
Please ensure the following boxes are checked off:

☐ Email address of the client or close support which can be used to receive the Zoom meeting invitation.

☐ Completed referral form and client's consent.

☐ Client must be aware that Zoom (video call) is the mode of communication for this service.

Available Services: Psychiatry

The Psychiatry pathway provides access to a psychiatrist for a **one time psychiatrist consultation**, with the goal of adding targeted support to a client's local care team. Services include: diagnosis support, medication review, and treatment care planning with client.

One may also have a PIT appointment. This is 30-minute zoom appointment with the patient's Family Physician or Nurse Practitioner along with patient and psychiatrist to address a specific question about diagnosis or treatment. (Presenting problem cannot be first break psychosis, long complicated affective disorder or primary problem of trauma.

Please fill in **ALL** the boxes in the form below (unless noted as optional). If it is a check box, please use an X. Incomplete referral forms may not be accepted. If you have questions related to the referral form, please contact the FNvSUPS office at 1-833-456-7655. We do not accept referrals without client knowledge.

Is the client aware of the referral and who initiated the referral?		Yes		No

Who should be contacted to book the appointment *(please select one):*	
	Client
	Person who referred the client
	Physician/NP + Client (PIT appointment)
	Other *(please specify):*

REFERRAL INFORMATION:

Name of person referring:	Role or capacity:	Length of time knowing the client:

MSP Billing #:	Phone:	Fax:	Email:

CLIENT INFORMATION:

Name:	Sex/Gender Identity:	Date of Birth (YY/MM/DD):

Address	Location (if different than address)

Email Address *(**essential** for* Zoom link):	Phone Number

Emergency Contact:	Emergency Contact Phone #:	Relationship of Emergency Contact:

Best Way to Contact Client (Email, Phone)	Personal Health Number (PHN):

Family Physician/Contact Information (if available):	Preferred Pharmacy:	Nearest Hospital:	Closest Laboratory Services:

Please fill out the form electronically and fax to FNvSUPS: 1-833-222-8131

*Please note, the next box of questions (in orange) is **OPTIONAL***

Does the client identify as....				**Is the client a member of a First Nations Community?**	
	First Nations		Metis		Yes
	Inuit		Non-Indigenous		No
Client Status Number: *(not required)*					

Referral Note: *(clinical notes can be included and attached if applicable. If attaching, please check **(X)** that your note contains the following sections):*

Question Referring Person wants answered:
Question Patient wants answered:
History of Presenting Illness:
Past Medical History:
Past Psychiatric History:
Medications:
Family History:
Social History of Note:

Please attach most recent labs (CBC, TSH, electrolytes, BUN, creatinine, B12)

Please include copies of relevant diagnostic tools used and mark X in the table below if attached

PHQ9 depression	Mood Chart	Sleep Chart	Sheehan Disability Scale	Adult ADHD Rating Scale/ ECG	GAD7 anxiety

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ADDITIONAL INFORMATION:

Do you feel there is a current risk of harm to self or others? *(Violence, self-harming behaviours, suicidal ideation, suicidal attempts, etc.)*	Is there a safety plan in place for the client? *If risk is assessed at medium or high, please attach the safety plan for your client to this referral form.*

Is there anything else that you want us to know? *Please also let us know how to create a safer environment for your client (i.e. triggers).*

CIRCLE OF CARE: *Include patient's circle of care or professional care team (family physician, NP, case worker, community nurse, social worker, etc.). During the appointment, the specialist will confirm directly patient's consent to share information with those named below.*

Name:	**Role:**	**MSP Billing #:**	**Email:**	**Phone:**	**Fax:**

Please fill out the form electronically and fax to FNvSUPS: 1-833-222-8131