Vancouver Coastal Health
*Promoting wellness. Ensuring care.*

# Youth Substance Use Services

Tel: Fax:

**DATE:**_____**PARIS #**_____

**PHN** _____

The below-named has come under the care of Vancouver Coastal Health. As permitted by the **Freedom of Information and Protection of Privacy Act**, we are requesting that copies of his/her records be forwarded to the fax number on the left.

**PATIENT DETAILS**

Name: _____ Gender: M / F / Trans

Permanent Address:_____ (city): _____ Age:_____

Telephone: _____ _____ DOB (dd/mm/yyyy):_____

**Primary Contact (name):** _____ Relationship: _____

Home Tel: _____ Cell:_____

**PERSON SUBMITTING REFERRAL**

Title _____

Name _____

Organization/office_____

Tel _____

Fax _____

**COMMUNICATION**

Language: _____

Need for translator? Y N

Memory: Impaired? Y N

Cognitively impaired? Y N

Insight impaired? Y N

Client have access to a phone

Y N

Can client attend clinic? Y N

**MEDICAL HISTORY AND DIAGNOSES (**please list all current diagnoses & any recent surgeries**)**

If the client is palliative (has less than a year), please call the Palliative Access Line @ 604-263-7255

**CURRENT MEDICATIONS (**attach list if available**):**

**ALLERGIES:**

**DISCIPLINE REQUESTED**

- □ **Nursing care** – please specify e.g. Wound care per Vancouver Health Wound Care Protocol, medication management/teaching, chronic disease management, etc
- □ **Occupational Therapy** – e.g. ADL, safety assessment, wheelchair/scooter evaluation, swallowing assessment
- □ **Case Management** – e.g. Mental Health assessment, Substance use services
- □ □ **Others** -- please specify →

**REASONS FOR REFERRAL / PHYSICIAN ORDER**

**CARE PROVIDERS INVOLVED:**

Primary Care Physician: _____ Tel: _____ Fax: _____

Specialist(s): _____ Tel: _____ Fax: _____

Other _____ Tel: _____ Fax: _____

**Physician's Signature** (Physician order required for wound care and medication management)

**Date** **Phone #**

**PLEASE FAX COMPLETED REFERRAL TO YSUS: 604 – 321 – 5108**