**Provincial Assessment Centre (PAC)**

**Referral Package**

Please complete all sections of the referral package; include supporting documents, assessments and reports. Completed referral packages can be faxed to the PAC Intake Coordinator at fax: 604-775-1127.

**Client Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Legal Name: | | | |
| Sex: | | Gender: | |
| Date of Birth: | | PHN: | |
| Address: | | | |
| City: | Postal Code: | | Phone: |

Type of residence (group home, apartment, etc.):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Level of support at home (eg. 24/7 staff, CLBC outreach inclusion hours, etc.):­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current location (if different from above):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Discharge plan or Urgent Discharge Plan (if different from residence): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Person Completing Referral**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Agency: |  |
| Position: |  | Fax: |  |
| Telephone: |  |  |  |
| Email: |  |  |  |
| Address: | | | |

**Current Services & Supports: (Mark all that apply)**

|  |  |  |  |
| --- | --- | --- | --- |
| Developmental Disability Mental Health (DDMH) |  | Public Guardian & Trustee |  |
| Health Services for Community Living (HSCL) |  | Counselling/Psychology |  |
| Residential (Group Home) |  | Behavioural Support |  |
| Residential (Home Share) |  | Day Program |  |
| Residential (Supported Independent Living) |  | Other: |  |
| Living with Family |  | Other: |  |

**Legal Status: (Mark all that apply and provide copies of relevant documentation)**

|  |  |  |  |
| --- | --- | --- | --- |
| Power of Attorney |  | Representation Agreement |  |
| Committee of Person |  | Probation Order |  |
| Child in Care |  | Other: |  |
| Outstanding Legal Charges |  | Other: |  |

**Cultural Information**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Does the client identify as an Indigenous Person?** | | | | | | | | |
| * Indigenous * Non-Indigenous | | | * Client declined, ask again later * Client declined, do not ask again | | | | * Unknown | |
| **Indigenous Identity Group** | | | | | | | | |
| * First Nations * First Nations & Inuit * First Nations & Métis * First Nations & Métis & Inuit | | | | * Inuit * Métis * Metis & Inuit | | * Unknown * Outside of Canada * No response | | |
| **Predominantly Lives** | | | | | | | | |
| * Both on & off reserve | | * Off reserve | | | * On reserve | | | * No response |
| **First Nations Status** | | | | | | | | |
| * Has Status | * Non Status | | | | * Pending Status | | | * No response |
| **Métis Citizenship** | | | | | | | | |
| * Has citizenship | Métis Citizenship #: | | | | | | | |
| * Non citizenship | | | | * Pending citizenship | | * No response | | |
| **Would you use Indigenous Patient Services?** | | | | | | | | |
| * Yes | | | | * No | | * Maybe | | |
| **Outpatient/Community Indigenous Supports? (please describe)** | | | | | | | | |
| **Status Card #:** | | | | | | | | |
| **Band:** | | | | | | | | |
| **Ethnicity:** | | | | | | | | |
| **Primary Language:**  **Interpreter needed?**   |  |  | | --- | --- | | * Yes | * No |   **Please provide details of language interpretation needs:** | | | | | | | | |

|  |
| --- |
| **We invite the client to let us know if there are any spiritual, religious practices or ceremonies that will support their wellness while in treatment:** |

Does the client have a trauma history? Yes / No If yes, please describe:

|  |
| --- |
|  |

**Reason for Referral to PAC / Goals of Assessment:**

|  |  |  |  |
| --- | --- | --- | --- |
| Diagnostic clarification & assessment |  | Pharmacologic review/treatment goals |  |
| Behaviour assessment/management |  |  |  |
| Other: |  |  |  |

**What would you like PAC to achieve with this individual?**

**Please comment on any special physical care needs, special equipment/devices used by the client:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have there been any hospitalizations (medical or psychiatric or other) during the last two years? Yes / No

Please attached discharge summaries from past two years of hospital admissions or detail below:

|  |
| --- |
|  |

**Income:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| * PWD * MSDRP | * CPP/CPPD * Income Assistance | * Employment Insurance * Other: \_\_\_\_\_\_\_\_\_\_\_ |  | * Certified/Extended Leave | * Certified/Extended Leave |

**Status under the BC Mental Health Act**:

|  |  |
| --- | --- |
| * Voluntary | * Certified/Extended Leave |

**The following information and forms are required with the client referral application:**

* Client Contact List (pages 6-7)
* Functional Level and Activities of Daily Living and Risk & Safety Concerns (pages 8-9)
* Psychiatrist Referral Form (pages 10-11)
* Client Authorization (page 12)
* MSDPR Comfort Allowance (page 13)

**Client Contact List**

|  |  |  |
| --- | --- | --- |
| **Agency/Role** | **Contact Details** | |
| Primary Contact | Name:  Phone:  Fax: | Email:  Address: |
| Next of Kin | Name:  Phone:  Fax: | Email:  Address: |
| Family Contact(s) | Name:  Phone:  Fax: | Email:  Address: |
| Representation Agreement Key Contact | Name:  Phone:  Fax: | Email:  Address: |
| CLBC Facilitator/Analyst | Name:  Phone:  Fax: | Email:  Address: |
| MCFD Worker(s) | Name:  Phone:  Fax: | Email:  Address: |
| Identified MRP or Prescribing Physician at the time of discharge from PAC | Name:  Phone:  Fax: | Email:  Address: |
| Psychiatrist | Name:  Phone:  Fax: | Email:  Address: |
| Mental Health Team – Primary Contact | Name:  Phone:  Fax: | Email:  Address: |
| HSCL Clinician/Contact | Name:  Phone:  Fax: | Email:  Address: |
| Occupational Therapist | Name:  Phone:  Fax: | Email:  Address: |
| Speech and Language Therapist | Name:  Phone:  Fax: | Email:  Address: |
| Behavioural Therapist | Name:  Phone:  Fax: | Email:  Address: |
| General Practitioner | Name:  Phone:  Fax: | Email:  Address: |
| Neurologist | Name:  Phone:  Fax: | Email:  Address: |
| Dentist | Name:  Phone:  Fax: | Email:  Address: |
| Other Involved Medical Specialist(s) | Name:  Phone:  Fax: | Email:  Address: |
| Pharmacy | Name:  Phone:  Fax: | Email:  Address: |
| Other: | Name:  Phone:  Fax: | Email:  Address: |

**Functional Information and Activities of Daily Living**

Please complete the information below noting normal routines, behavioural issues of concern, staff support requirements, and any safety protocols or safety equipment utilized in the delivery of care/services.

**Activities of Daily Living**

|  |  |
| --- | --- |
| Sleep Patterns |  |
| Communication |  |
| Family & Social Relationships |  |
| Likes/Dislikes |  |
| Mobility |  |
| Feeding |  |
| Personal care / Hygiene |  |
| Dressing |  |
| Elimination / toileting |  |
| Special Care Needs |  |

**Risk and Safety Concerns**

Please specify context of behaviours (eg. only at home, in community, triggers, etc.)

|  |  |
| --- | --- |
| Choking |  |
| Falls |  |
| Seizures |  |
| Self-injurious/harm behaviours |  |
| Aggression towards objects |  |
| Aggression towards people |  |
| Elopement |  |
| Exploitation / victimization |  |
| Substance use  *Please describe the client’s pattern of caffeine, nicotine, and any illicit substance use* |  |

**Psychiatry Referral**

TO BE COMPLETED BY PSYCHIATRIST ONLY

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Psychiatrist Contact Information** | | |
| Name: |  | |
| Phone: |  | Fax: |
| Email: |  | |
| Please confirm if the psychiatrist identified above will continue to follow the client after discharge from PAC:  Yes / No | | |

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

**Please complete *OR* attach consultation notes relevant to this referral.**

Allergies and/or sensitivities (drugs, food, other):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dietary concerns / restrictions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diagnosis** (DSM IV or V)

|  |
| --- |
|  |

Previous pharmacogenomics testing? Yes / No (if yes, provide reports)

Previous Genetics testing? Yes / No (if yes, provide reports)

**Current Medication List** (Complete below or attach a current list)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Drug | Dose/Frequency/Route | Therapeutic Purpose | Date Started | Effect/Comment |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Clinical Presentation** (Please provide a brief psychiatric history and current presenting features that you would like assessed)

|  |
| --- |
|  |

**Medical History** (Please provide details on any current or historical medical diagnoses)

|  |
| --- |
|  |

**Client Authorization**

**Client Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Legal Name: | | | |
| Date of Birth: | | PHN: | |
| Address: | | | |
| City: | Postal Code: | | Phone: |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization for the Collection, Use and Disclosure of Information**

* I hereby permit the Provincial Assessment Centre, operated by Provincial Health Services Authority to collect, use, and disclose personal information related to the above named client for the purposes of assessing eligibility, provision of services, and ongoing consultation with the following listed professionals and agencies:
  + - Community Service Agencies, Day Program Providers, Rehabilitation Service Providers, Police Agencies, Physicians, Hospitals, and other related Clinical or Community Support Services/Providers.
* I hereby consent to receive treatment/services from the Provincial Assessment Centre, operated by Provincial Health Services Authority.

I have read and understood this consent form. Yes No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client or Legally Authorized Representative\* Date (dd/mm/yy)

\*In most cases, the client should sign this form. If another person signs, please attach a copy of the document assigning legal representation (this does not include Power of Attorney).

Clients, or their legally authorized representatives, can revoke or alter this consent at any time and are encouraged to contact the Provincial Health Services Authority, Provincial Assessment Centre if they wish to do so. This consent will expire 90 days after the client is discharged from the program.

**MSDPR Comfort Allowance**

For individuals who are receiving income from the Ministry of Social Development and Poverty Reduction, their monthly allowance (cheques) will be reduced to the Comfort Allowance only. For individuals who have housing and rent to be maintained, PAC will liaise with MSDPR upon admission to the PAC program to have the individual’s rent maintained for the duration of their admission to the program. Upon discharge from PAC, the individual will go back to receiving their full monthly community rate for allowance (cheques) from MSDPR.

We ask that individuals or their financial representative(s) sign below that they are aware they will only receive the Comfort Allowance while admitted to PAC.

I have read and understood this information: Yes No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client or Legally Authorized Representative\* Date (dd/mm/yy)

Please contact the PAC Access and Discharge Coordinator at 604-660-0228 ext. 336525 if you have questions about this information.

**Required Supporting Documentation Checklist**

* Completed referral form (pages 1-13, note that any omissions will result in delays)
* Recent Psychiatric Consultation/Assessment
* Psychiatric Assessments (community intake psychiatric assessment, discharge summaries from psychiatric admissions to hospital, etc.)
* Copy of Personal Guardianship (Committee) and Representation Agreement (where applicable)
* Diagnostic Imaging reports (as available)
* Any previous genetic testing and medical geneticist reports (please fax an ROI’s to health record department at Medical Genetics Clinic)
* Any pharmacogenomics reports (if available)
* Laboratory investigations (within last 12 months)
* Current medication list/profile (or a MAR if the client is coming from an acute site)
* All psychology assessments
* Any available OT and SLP assessments
* Behaviour Support Plans
* Current Care Plans
* BC Mental Health ACT Form 4’s x two and all Form 6’s (if applicable)
* Discharge Commitment / Return Agreement (if the client is coming from an acute site)