Child Youth & Family Mental Health Services
Queen Alexandra Centre for Children's Health
2400 Arbutus Road Victoria BC V8N 1V7

Ledger Inpatient Stabilization Referral Form

MANDATE

Ledger Inpatient Stabilization program is a regional service which provides short term stabilization and crisis intervention to children, youth and their caregivers. Our goal is to communicate as much as possible with caregivers and involved professionals throughout the patient's short stay. Ongoing involvement of community physicians and mental health professionals is essential.

ELIGIBILITY CRITERIA

- 16 years and below (up to 17th birthday).
- Severely acute psychiatric presentations such as florid psychosis, active mania or imminently suicidal with serious previous attempts.
- Medically stable.

REFERRAL PROCESS

1. **Complete this 2 page form (please print) and fax to Intake at 250-519-6789.**
2. **Ensure all information is filled out as completely as possible.**
3. **The consent portion of this form must be signed by the legal guardian and youth 12 years and older (unless certified under the Mental Health Act) before the referral will be considered.**
4. **If you wish to discuss the referral before submitting, phone Intake at (250) 519-6720 or (250) 519-6794.**
5. **Include any collateral documentation, relevant reports, etc. and fax to Intake at 250-519-6789.**
6. **After hours please call the stabilization unit at 250-519-6727 and speak with the nurse in charge.**

Referral Source – Referring Physician or Mental Health Clinician		
Name:		**Phone #:**
Patient Information		
Full Legal Name:		
Preferred Name:		**DOB:**
Current Address:		
City:	**Province:**	**Postal Code:**
	Phone #:	**Cell #:**
Gender: ☐ **Female** ☐ **Male** ☐ **x Gender** ☐ **Prefer not to disclose** **Preferred pronoun:** ☐ **She/her** ☐ **He/him** ☐ **They/them**		
Do you self-identify as Indigenous? Yes ☐ **No** ☐		
PHN:	**School:**	**School Phone #:**
Parent/Guardian Information		
Legal Guardian Name:		**Relationship to Patient:**
Current Address:		**Phone #:**
City:	**Province:**	**Postal Code:**
Patient resides with (if different):		**Relationship to Patient:**

Consent *To Be Signed By Legal Guardian & Youth 12 Years and Older*

I _____*(Legal Guardian)* and _____*(Child/Youth 12yrs+)*
Give consent to CYFMHS employees to receive and share information related to the mental health assessment & treatment needs of _____ with other professionals in order to facilitate the provision of continuing care.

Signature of Guardian: _____ **Date Signed:** _____

Signature of Child/Youth: _____ **Date Signed:** _____

Signature of Witness: _____ **Date Signed:** _____

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Referral Information

What is the reason for this referral? Please specify: Diagnosis/Relevant Medical History & Impact on the patient's functioning

Are there any current safety concerns? Please specify:	**Current level of observation:** ☐ Constant ☐ Close ☐ Q5 ☐ Q15 ☐ Q30 ☐ History of Violence Alert ☐ Certified* Please fax documents

☐ Self Harm	☐ Suicidal Ideation	☐ Aggression	☐ Other(specify):

What are the PSYCHIATRIC CONCERNS? Please check ALL that apply

☐ Anger/Oppositional behaviour	☐ Hallucinations/Delusions/Psychosis	☐ Peer Relationship Difficulties
☐ Anxiety	☐ Hyperactivity	☐ School Difficulties
☐ Behaviour/Dysregulation	☐ Inattention	☐ Sleep Problems
☐ Depression/Mood	☐ Learning Difficulties	☐ Substance Use
☐ Developmental Delay	☐ Obsessions/Compulsions	☐ Other (please describe)

Current Medications (including dosage):

How can we best meet this patient's cultural and/or spiritual needs?

Has this patient been referred to any other programs? If yes please specify below:

Has this patient seen any of the following? If yes, please specify name and contact information:

☐ **Family Physician:**

☐ **Pediatrician:**

☐ **Psychiatrist:**

☐ **Psychologist:**

☐ **Counsellor:**

☐ **Community Mental Health Team:**

☐ **Other professionals involved? If yes, please specify name and contact information:**

Please indicate who may be following up with this patient after Ledger admission is completed:

Prescribing Physician (if indicated): _____

Community team if available: _____