[](https://www.google.com/url?esrc=s&q=&rct=j&sa=U&url=https://en.wikipedia.org/wiki/Island_Health&ved=2ahUKEwiG0YKwtdTzAhVPqJ4KHWSLAjsQqoUBegQIAxAB&usg=AOvVaw2R2Hy9g8IQE45ZjbaU1Bq_)

**Child and Youth Virtual**

**Psychiatry Consult Clinic**

**Please FAX Referral: 250-519-5159**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | | | | |
| **DATE OF REFERRAL:** | | | **PERSONAL HEALTH NUMBER:** | | |
| **LEGAL NAME:** | | | **PREFERRED NAME:** | | |
| **DOB:** | **PRONOUNS:** | | **PHONE:** | | **CELL:** |
| **LEGAL GUARDIAN NAME:** | | | **GUARDIAN PHONE:** | | |
| **REFERRING PHYSICIAN/NP:** | | | **MSP BILLING NUMBER:** | | |
| **IS THE CLIENT ATTACHED TO AN**  **ISLAND HEALTH TEAM? ☐ YES ☐ NO** | | **TEAM:** | | **TEAM CLINICIAN:** | |
| **WHO DO WE CONTACT TO SCHEDULE APPOINTMENTS AND SEND FORMS TO?**  **NAME AND RELATION TO YOUTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |
|  | | | | | |
| **REFERRAL QUESTION and PERTINENT PSYCHIATRIC HISTORY *(Attach any additional information you feel would be helpful)***  **MEDICAL DIAGNOSIS / RELEVANT MEDICAL HISTORY / CURRENT MEDICATION *(Include dosage)***  **ARE THERE ANY CURRENT SAFETY CONCERNS?**  **☐ SELF-HARM ☐ SUICIDAL IDEATION ☐ SUICIDE ATTEMPT(S) ☐ AGGRESSION/VIOLENCE ☐ HOMICIDAL IDEATION ☐ PSYCHOSIS**  **☐ OTHER (PLEASE INDICATE):** | | | | | |
|  | | | | | |
| **ARE THERE FAMILY MEMBERS, FRIENDS, OR SUPPORT WORKERS IMPORTANT TO THE YOUTH, WHO THEY WOULD LIKE TO BE INVOLVED IN THEIR CARE? ☐ YES ☐ NO**  **DETAILS:** | | | | | |
| **CONSENT TO REFERRAL ☐ YES ☐ NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  ***(Youth to sign or HCP documents Verbal Consent)***  **CONSENT TO GATHER COLLATERAL FOR THE PURPOSES OF INTAKE ☐ YES ☐ NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  ***(Youth to sign or HCP documents Verbal Consent)*** | | | | | |
| **IS THE YOUTH CONNECTED WITH ANY OTHER RESOURCES? PLEASE PROVIDE CONTACT INFORMATION:**  **AGENCY: ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGENCY: ­­\_\_\_\_­\_\_­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGENCY: ­­­­­­­\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **CONTACT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CONTACT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CONTACT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |

## PROGRAM INFORMATION AND REFERRAL INSTRUCTIONS

A completed referral form should be faxed directly to the Virtual Psychiatry Consult Clinic

## Please note: This service is intended to provide a one-time consultation service, where clarification of diagnosis and a proposed treatment plan is desired. Wait times fluctuate depending on acuity and demand.

## Benefit to patients:

* Decreased travel time/cost compared to an in-person consult
* Easier to have family or other local support attend with the patient

## Benefit to local resources:

* Access to psychiatric consults for children and youth
* Decreased wait times for patients
* A dictated report from a child & youth psychiatrist to clarify diagnosis and establish a treatment plan

**Who can refer to this service?**

* Family Physician, Nurse Practitioner, or Pediatrician
* Discovery, YSTAR, and YCC teams may refer to this service with a physician referral

## What is the referring clinician’s role?

* Determine the client’s suitability for receiving service - *see next page for inclusion/exclusion criteria*
* Physician faxes a completed Virtual Psychiatry Consult Clinic referral form requesting a psychiatric consultation, noting relevant background on the patient, contact information for the Legal Guardian, and a clear referral question.

**What happens next?**

* Referral will be reviewed, and if accepted, the identified contact will be notified to schedule a consult. A letter will be faxed to physician/nurse practitioners for notification of the appointment.
* If the referral is declined/redirected, the referring clinician will be notified with the rationale.
* Consent, screening tools, family, and school forms are required to be completed prior to the appointment, and will be sent to the identified contact. The identified contact will be directed to submit the completed forms to your office (if they do not have access to a fax machine).
* **Please fax forms** to Virtual Psychiatry Consult Clinic | Fax #250-519-5159

## Can the patient meet with a psychiatrist in person?

* Consults are virtual only.

## What can the patient expect during a session?

* They can see, hear, and talk to the child and youth psychiatrist
* Assessments generally take 90 minutes to complete
* Review of consent and confidentiality
* There may be time for subgroups to meet with the psychiatrist separately- within the 90 minute time frame
* The physician has reviewed all written collateral information that has been provided; any interested party is welcome to submit written information for review
* Opportunity to ask questions
* A family member or other trusted resource can attend with the patient
* If others are present in the room with the patient, the patient has the right to ask that the person(s) to leave the room for part of the consult
* There may be a psychiatric trainee present and participating during appointment
* A written report will be generated and sent to the community based physician or nurse practitioner

## How is privacy protected?

* All Virtual Psychiatry Consult Clinic sessions adhere to the Freedom of Information and Protection of Privacy Act. Sessions are not recorded.

**Referrals**

Inclusion Criteria:

* Ages 5-18 years;
* Children/youth with functionally impairing mental health concerns, including ADHD if part of a complex presentation;
* Children under the age of 14 years with an intellectual disability;
* Youth with concurrent disorders;
* Youth who consent to participate; and/or,
* Consults that are non-urgent.

Exclusion criteria:

* Second opinion for a complex Tier 5 presentation requiring a multidisciplinary team assessment such as VICAN or Ledger Inpatient;
* Patients currently under the care of another psychiatrist (unless seeking a second opinion);
* Patients who are acutely ill with psychosis or active suicidality;
* Patients requiring a substance use disorder assessment (only);
* Patients who have not yet been trialed with first-line medications *may be redirected*;
* Patients requiring initial ADHD only assessment;
  + *ADHD as part of a complex presentation are acceptable;*
* Patients with a primary concern of an eating disorder;
* Patients requiring an autism assessment; and/or,
* Patients connected with Child and Youth Mental Health (CYMH at MCFD).