Vancouver Coastal Health

Vancouver Community
OLDER ADULT Mental Health & Substance Use
Referral Form

Phone: 604-873-6733 **Fax:** 604-872-0254
Hours of operation: Monday to Friday 8:30am to 4:30pm, except statutory holidays

IF YOUR CLIENT IS IN CRISIS AND REQUIRES IMMEDIATE HELP, PLEASE CALL 911 OR DIRECT THEM TO THE NEAREST EMERGENCY DEPARTMENT.

INSTRUCTIONS and INFORMATION

SERVICE ELIGIBILITY

The Vancouver Community Older Adult Mental Health and Substance use program provides specialist support and treatment to older adults (generally aged 65 and older), with mental health (MH), substance use (SU), and concurrent MHSU disorders or conditions that co-exist with a combination of age-related psychological, cognitive, functional, physical and social needs.

Program criteria:

1. **Individuals, generally aged 65 and older, who require specialized care for:**
   - Recently developed mood-related symptoms, anxiety, psychosis and/or problematic substance use.
   - Enduring mental illness and/or substance use disorder and the coexistence of impairments in multiple domains related to the aging process: physical, cognitive, social and functional, which complicate their psychiatric care and are complicated by poor primary treatment response, risk of relapse, or poor treatment adherence.
2. **Individuals of any age with:**
   - ***Complex behavioral and/or psychological symptoms associated with a progressive dementia.
     *Complex = symptoms are often severe, there are significant challenges with treatment then and several other complicating factors, including psychological, social, environmental and biological factors.

Please note:

- We do not serve individuals with cognitive impairment and behavioral and/or psychological symptoms specifically related to a non-progressive neurocognitive disorder, such as that associated with acquired brain injuries. These individuals require a different type of care and support expertise than can be provided by the VC OA MHSU Program.
- We do not offer stand-alone capacity assessments.
- We do not offer crisis services.

HOW TO REFER TO OLDER ADULT MENTAL HEALTH & SUBSTANCE USE PROGRAM

1. Complete the VC OA MHSU Referral Form and fax to 604-872-0254. Missing or incomplete information will delay referral processing.
2. Please ensure the referred person (or their Substitute Decision Maker where appropriate) is aware of the referral.

To support the referral, please provide:

- ☐ Current medication and allergy lists.
- ☐ Lab results within last 3-6 months: Suggest CBC, differential, Na, K, creat, eGFR, Ca+, albumin, +/- protein, GGT, AST+/- Alk phos, TSH, Serum B12, therapeutic blood level for monitoring (such as lithium as applicable), urinalysis.
- ☐ Diagnostics: CT head /MRI, ECG if done previously.
- ☐ Scales/scores (e.g., frailty scale, GDS, MMSE, MoCA) as relevant.
- ☐ Relevant consults (e.g., geriatrician, neurology, psychiatry).

Please do not send collateral information available in EMR, Care Connect, CERNER, PARIS and Pharma Net.

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Please indicate if any of the following apply:

◯ Acute or tertiary mental health unit discharge	◯ Extended Leave	◯ **Current** severe behavioral responses (progressive dementia)	◯ **Current** suicidal ideation

CLIENT INFORMATION			
FIRST Name:	LAST Name:	Date of Birth: DD MM YYYY	Age:
PHN:	PARIS ID: (if known)	Phone #:	
Address: (***Vancouver Residents ONLY ***)			
Preferred Language:		Interpreter required? ◯ Yes ◯ No	
Name of Primary Care Provider (Physician/NP):		Phone Number:	
		Fax Number:	
Is the Primary Care Provider (if not the referrer) aware of and agreeable to the referral? ◯ Yes ◯ No			
Other services/supports/specialists involved or referrals pending: *(Please attach specialist consultation notes)* ◯ None ◯ Home Health ◯ Geriatrician ◯ Neurologist ◯ Psychiatrist ◯ Other:			

REFERRAL DESCRIPTION
Reason for referral: (What is the presenting concern that requires an **older adult** mental health and/or substance use referral at this time?)
What is the desired outcome?
Are there current risks of concern? ◯ Yes ◯ No
If yes, please specify:
How long has this been a concern? ◯ Less than 1 month ◯ 1 to 6 months ◯ More than 6 months
What actions have been taken to address concern(s) and associated risk(s) in the past 6 months?

MISSING OR INCOMPLETE INFORMATION WILL RESULT IN THIS FORM BEING RETURNED FOR COMPLETION.

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To be completed by ACUTE AND TERTIARY MENTAL HEALTH CARE units only	
Hospital/Unit Name:	Estimated discharge date: DD MM YYYY
Extended Leave: ◯ Yes ◯ No Next Review Date: DD MM YYYY	Review panel hearing scheduled: ◯ Yes ◯ No Date: DD MM YYYY
Long acting depot medication ◯ Yes ◯ No Last administered: DD MM YYYY	Medication: Next due: DD MM YYYY
Please attach applicable Mental Health Act forms (if not available in Cerner)	

To be completed by LTC HOMES only		
LTC Home:	Phone #:	Fax #:
Director of Care (or designate) Name:		
Please attach:		
☐ Up to date individualized care plan related to mental health and/or behavioral concern	☐ 7-day behavior tracking tool (BSO-DOS, 24 hr Close Observation, etc.)	
☐ Current medication administration record including prn medications	☐ Most recent RAI-MDS Outcome Scales trend report	

REFERRING SOURCE INFORMATION		
Please indicate the preferred day/time to make contact with you (or identify an alternate person we can contact) regarding the referral.		
Name:	Phone #:	Fax #:
Preferred day/time to contact:		
Alternate contact:	Phone #:	
Date of referral: DD MM YYYY		

CONSENT TO REFERRAL

Client is aware and consents to referral and sharing of information? ◯ Yes

OR

If the person does not have capacity to consent, please provide the contact information for the *Substitute Decision Maker (SDM) who has provided consent on behalf of the client.

SDM Name: Relationship: Phone Number:

* *A Substitute Decision Maker (SDM) is a person who helps make or makes decisions on behalf of another adult if and when the adult is unable to make them.*

◯ **Supplemental information attached.**

For office use only

Date referral received:

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