



**CAMPBELL RIVER REFERRAL FORM**  
**FAX TO: 1-866-931-0211**

Last Name:		First Name:		Date of Birth: (dd/mm/yy)
Address: (incl. postal code)				MRN (if applicable):
Home Phone:	Cell Phone:	Lives alone? <input type="checkbox"/> Yes <input type="checkbox"/> No		PHN:
Alternate Contact:	Relationship to Client:	Alternate - Home Phone:	Alternate - Cell Phone:	

**Reason for Referral:** Please comment on the condition of your patient and the desired outcome.

**Please indicate what *Island Health Service(s)* your patient requires:**

**COMMUNITY HEALTH SERVICES** - enables individuals with health-related problems to remain independent in their own homes.

<p><b>Case Management</b></p> <input type="checkbox"/> Assessment <input type="checkbox"/> Adult Day Care <input type="checkbox"/> Assist/Living <input type="checkbox"/> Residential care access	<p><b>Community Rehab</b></p> <input type="checkbox"/> OT & PT <input type="checkbox"/> Home Safety <input type="checkbox"/> Equipment Needs <input type="checkbox"/> Mobility <input type="checkbox"/> Exercises	<p><b>Geriatric Specialty Services</b></p> <input type="checkbox"/> Geriatric Medicine <input type="checkbox"/> Geriatric Psychiatry <small>*Patient Assessment must be completed, see back of page for details</small>
<p><b>Nursing</b></p> <input type="checkbox"/> Home Health Monitoring Service* <input type="checkbox"/> Palliative <input type="checkbox"/> HSCL – Health Services for Community Living Clients <input type="checkbox"/> Wound Care <input type="checkbox"/> Lower Limb Assessment <input type="checkbox"/> Nurse Practitioner Care of Elderly*	<p><b>Home Support</b></p> <input type="checkbox"/> Personal Care <input type="checkbox"/> Respite	<p><b>Social Work</b></p> <input type="checkbox"/> Social/income advocacy & navigation; adult abuse, neglect & self-neglect

**MENTAL HEALTH & SUBSTANCE USE** – multidisciplinary services for people with mental health and substance use problems.

- Intake Assessment – screening and service matching
- Post-Partum Support – *Olive Branch Group*/Reproductive Mental Health Support
- Collaborative Care – psychiatric consultation with up to 2 follow up visits. **Patient Questionnaire must be completed.**
- Health Consultant\* – new service; please refer to back for description.

**Questions: (250) 850-2620**

**WELLNESS CENTRE at Campbell River Hospital** – chronic disease management

- Chronic Disease Management – individual management & support by RN & access to CDM exercise program for chronic conditions that can include chronic pain, COPD, hypertension, depression, arthritis
- Social Work for Chronic Disease Management - psych-social, physical and mental health support
- Dietitian Support for Outpatient Nutrition Services
- Health Matters Group Education – hypertension, heart healthy eating, COPD, weight management, stress, sleep, healthy feet, chronic pain
- Heart Health Education & Support - can include individual management, group heart education and access to "*Take Heart Breathe Well*"

**Questions: (250) 286-7151**

Date of Referral:	Physician/NP Name: (please print)	Physician/NP Stamp:
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## WHEN REFERRING TO GERIATRIC SPECIALTY SERVICES THE FOLLOWING INFORMATION IS REQUIRED

\***Geriatric Specialty Services** includes specialized care for seniors who are complex with unstable, often co-morbid psychiatric and/or medical issues, frailty and/or functional decline. Referrals for a Geriatric Psychiatrist or Geriatrician must come from a Physician. The specialists do work within an inter-professional team to assess and manage complex psychiatric and medical conditions for elderly clients.

Please complete this patient assessment:

- Geriatric Medicine
- Geriatric Psychiatry
  - Safety Issues (*Elder abuse, wandering risk, fire etc.*)
  - Cognitive Issues
  - Dementia
  - Aggressive or psychotic behavior
  - Mood Disorder
  - Previous psychiatric involvement
  - Drug or alcohol abuse
  - History of Falls
  - Mobility Issues
  - Complex Medical/Health

## Descriptions of New Roles

**Home Health Monitoring** *\*new service* - a service supporting people living with **heart failure** or **COPD** that can be managed at home. The aim is to improve patient's knowledge of their chronic disease, and increase ability to self-manage. Easy to use equipment is installed in the home.

**Nurse Practitioner Care of Elderly** *\*new role* – working with frail elderly with complex, high intensity co-morbidities requiring intensive medical and chronic disease management.

**Health Consultant** *\*new role*– works with physicians and their clinic teams to address the needs of individuals with chronic, complex mental health and substance use issues in combination with other social determinants of health.