Doctor's Referral Form

Foundry Campbell River accepts referrals from professionals, community members, and family members for young people ages 12 to 24. Youth are also welcome to walk in during our drop-in hours to request any services they require, with or without a referral. This form may be delivered in person at 140 10th Ave, or faxed to Foundry's confidential fax number: 250 286 3650

Foundry aims to be a safe space for all youth, including those who identify as Indigenous, POC, LGBTQ+, or Trans.

Drop-in Hours:

Monday 9 – 11 am & 1 – 3 pm
Tuesday – Thursday 1 – 6 pm
Friday 9 – 11 am

To book an appointment:

Call (250) 286-0611
Office hours: Monday & Friday 8:30 am – 4:30 pm
Office hours: Tuesday – Thursday 8:30 am – 6 pm

Date of referral _____ Urgent? YES NO

Youth Info

Preferred name:	Age:	Birth date (if under 19):
Legal name (if different):	Gender:	Preferred Pronouns
Youth Cell:	Okay to text or leave message on cell?	
Home Phone:	Okay to leave message at home #?	
Address	Aboriginal? YES NO Nation/Band:	
Personal Health Number:	Doctor/General Practitioner:	

Significant Others (parent, guardian, or other responsible adult)

Name	Phone number:	Okay to contact this adult? YES NO
Name	Phone number:	Okay to contact this adult? YES NO
Name	Phone number:	Okay to contact this adult? YES NO

Reason for requesting services:

Length of doctor/patient relationship: _____

Has this young person received services at Foundry previously? YES NO NOT SURE

What services offered at Foundry might be helpful now? Check all that apply:

- ☐ Psychiatry *(fill out and sign the Request for Psychiatric Services section)*
- ☐ Health Care: Doctor/N.P. appointment
- ☐ Sexual Health: Youth Clinic Nurse
- ☐ Mental Health Support & Counselling
- ☐ Substance Use Support & Counselling
- ☐ Youth and Family Conflict Resolution
- ☐ Free Groups and Courses
- ☐ Peer Support/Youth-in-Residence
- ☐ Cultural Support/Elder-in-Residence
- ☐ Aboriginal Youth Navigator
- ☐ Outreach Worker
- ☐ Employment Information and Support
- ☐ Housing Support
- ☐ Independent Living
- ☐ Not sure, would like to explore options.
- ☐ Other: _____

Is family being referred as well: YES* NO

***If yes, what family supports might be helpful:**

- ☐ Parent Support Group
- ☐ Family Conflict Resolution
- ☐ Counselling for family members affected by youth's substance use.

Other Involved Professionals / Supportive People

Name:	Role / Relationship:	Phone number:
Name:	Role / Relationship:	Phone number:
Name:	Role / Relationship:	Phone number:

Relevant additional information:

Are there any known risk factors for Foundry/John Howard staff while working with this client?

(e.g., physical or aggressive behaviour; threats made by others to this client; etc.) **YES** **NO**

Request for Psychiatric Services *If requesting psychiatry, please fill out this section and sign.*

After review, it is my view that this patient will benefit from an assessment and consultation with a psychiatrist.

Clinical Question:

Current / Previous Diagnoses:

Current Medications:

Previous Hospitalizations:

Brief Psychiatric & Medical History:

The following reports and assessments will accompany this referral:

- ☐ Hospital Report(s)
- ☐ Lab Report(s)
- ☐ Medical Imaging
- ☐ Clinical Notes / Assessments
- ☐ Self-Reports/Screens _____
- _____
- ☐ Other: _____
- ☐ Other: _____

_____ _____

Practitioner Signature *Date*