BC Neuropsychiatry Program
UBC Hospital, Detwiller Pavilion
2255 Wesbrook Mall
Vancouver, BC V6T 2B5

Phone: 604-822-9758
Fax: 604-822-7491
Website: www.bcnp.ca

UBC Hospital, Vancouver
Hillside Centre, Kamloops

BC Neuropsychiatry Tertiary Outpatient Referral Procedure

PLEASE READ THIS PAGE PRIOR TO COMPLETING PAGE 2

Due to high volume of demand for our program's tertiary services, our physicians are often only able to provide a one-time and/or second opinion to the patient's general, treating psychiatrist.

All referrals must include documents confirming the support of a treating psychiatrist. Ideally, all referrals to BCNP should be completed by the patient's psychiatrist.

We accept referrals for consideration to the UBC Neuropsychiatry Program for patients with:

- Dementia of any cause, with either major behavioral or psychiatric components, and/or a need to exclude a causal or contributing psychiatric illness (e.g. pseudodementia)
- Neurological disease, injury or condition leading to a psychiatric presentation
- Episodic disturbances thought to possibly result from a neurological disorder, such as epilepsy
- Unresponsive states, such as catatonia
- Movement disorders that require psychiatric interventions such as tardive dyskinesia, Parkinson's disease or Huntington's disease
- Somatoform & conversion disorders

Please note:
WorkSafe BC cases must be referred via a WorkSafe BC medical advisor.

We do not accept:
Patients for neuropsychological testing.
Patients with active medical legal cases, including ICBC.

Please fully complete page 2 and fax to 604-822-7491

Vancouver Coastal Health
Promoting wellness. Ensuring care.

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OUTPATIENT TERTIARY REFFERAL

PLEASE ENSURE ALL REQUESTED INFORMATION IS INCLUDED; FAX TO (604) 822-7491.

Please note that WorkSafe BC cases must be referred via a WorkSafe BC medical advisor.
We do not accept patients for neuropsychological testing or with active medicolegal cases, including ICBC.

Date of Referral: _____

GOAL FOR REFERRAL: _____

_____

Patient's Surname: _____ **First name:** _____

PHN: _____ DOB: d/m/y _____ AGE: _____ Sex: M / F

Address: _____ Postal Code: _____

Daytime Telephone: _____ Alternate Tel: _____

****

Referring Physician: _____ Billing #: _____ Specialty: _____

Office Tel: _____ Fax: _____ Private line: _____

Office Address: _____ Postal Code: _____

Family Physician: _____ Tel: _____ Fax: _____

Patient's current ongoing care provided by:

Psychiatrist: _____ Phone: _____ Fax: _____

Neurologist: _____

Mental Health Team: _____

Other: _____

Please include the following with this referral:

MANDATORY: Initial and follow up consultations from treating psychiatrist ☐
My patient does not have an active medico/legal case, including ICBC ☐

WHEN AVAILABLE:

- Initial and follow up consultations from neurologist ☐
- Previous neuro-imaging reports (CT, MRI) ☐
- Previous neuropsychological testing ☐
- Recent laboratory data ☐