BC CHILDREN'S HOSPITAL
An agency of the Provincial Health Services Authority

Unit area:

Name:

Date of birth:

MRUN:

Physician:

Social Work Referral-Consultation Services

Send to Fax: (604)875-2770 Phone: (604)875-2149

REFERRAL SOURCE

Date of referral: _____ clinic area: _____
Referring person and position: _____
Contact number & Email for referrer: _____
Is referral urgent? Yes____ no_____
Upcoming clinic visit date: _____

PATIENT/FAMILY CONTACT

Parent(s)/guardian(s): _____
Relationship: _____
Phone: _____
Address: _____
Email: _____

IS THE FAMILY AWARE OF THIS REFERRAL? YES _____ NO _____

REASON FOR REFERRAL

□ Safety/Risk: **Please Explain**_____
_____
□ Psychosocial Assessment and Crisis Intervention: **Please Explain** _____
_____
□ Access to Resources: Urgent ___ Non-Urgent ____**Please Explain** _____
_____
Additional Information: _____
_____
_____

HAVE YOU REFERRED TO ANY OTHER PROFESSIONAL SERVICE?

□ Psychology □ Child Life □ Other: _____

INTERNAL USE ONLY: SOCIAL WORK INTAKE

Date/ Time Received: _____

Date/Time Assigned: _____ Assigned To: _____

Social Work Intervention: _____
_____
_____
_____
_____
_____

Original for medical chart
Cc for social work office