Compassionate Connections Mental Health Care
444-2055 Commercial Dr.
Vancouver, BC V5N 0C
Website: www.ccmhc.ca
Phone: (778) 775-1550/ Fax: (778) 775-1551/ Email: admin@cchmc.ca

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A) Referring Clinician's Name: _____
Referring Clinician's registration #_____
Date of Referral_____
Referring Clinician's Tel. No. _____
Referring Clinician's Fax No._____

B) Patient Information
First name: _____
Surname: _____
DOB: Day_____ Month _____ Year _____
Gender_____ Marital Status: _____
Address: _____
Patient phone_____ Patient e-mail_____
Next of Kin_____
Relationship to Client _____Phone 1: _____
Phone 2: _____

C)
1. Reason for Referral
Anxiety ☐
Low Mood/ Depression ☐
Grief/Loss ☐
Trauma ☐
Burnout/Emotional Fatigue ☐
Psychotropic Medication ☐ (Please note that CCMHC does not offer prescriptions for

controlled substances such as opioid agonists or ADHD stimulant medications)
Disordered Eating ☐
Other ☐

_____

2. Current symptoms:

_____

3. Mental Health
History:_____
Psychiatric Diagnoses:

_____

Current medications prescribed:

_____

4. Eligibility requirements
**We can currently only accept patients with mild to moderate mental health conditions:*

We are not able to accept patients:
• *Whose primary concern revolves around alcohol or drug use and/or are so impaired by alcohol/ drug use that it would adversely affect therapeutic connection*
• *Who are actively suicidal or at risk of harm to self*
• *Who are at risk for harming others*
• *Who are cognitively impaired; MMSE should be >27*
• *Struggling with psychotic disorder*
• *Struggling with aggressive behaviors*
• *Struggling with personality disorder concerns to an extent that would a) adversely affect therapeutic connection or b) make virtual mental health care a suboptimal option*
• *With past or current concerns around mania*
• *Struggling with severe (crippling) depression*
• *Struggling with severe (crippling) anxiety*
• *Who are currently connected to/ have an active ongoing relationship with a psychiatrist*
• *Recently hospitalized / struggling with multiple ongoing presentations to hospital for mental health concerns*

5. Has this patient been recently seen by psychiatry? No ☐ Yes ☐

If yes, please share the name/ contact info of the psychiatrist:

Psychiatrist's Name: _____
Phone number: _____

6. Does this patient have current / past involvement with any of the following:

- Legal ☐
- Child Abuse Services ☐
- Insurance Concerns/ Worksafe ☐
- Immigration ☐
- Anger management programs ☐
- Other ☐

7. Is this patient aware CCMHC offers only virtual sessions and agreeable to this?

Yes ☐

No ☐

** Please fax your referral to: (778) 775-1551. Thank you for your referral. **