BC Epilepsy Society Mental Wellness Program Physician Referral Form

If you have a patient with epilepsy who would like to take part in the BC Epilepsy Society Mental Wellness Program, please complete this form in its entirety and fax it to **1-604-260-0978** or send the form as an email to **sonia@bcepilepsy.com**

Patient Information

DOB:

Last Name: First and Additional Names:

PHN: Gender:

Address: Street, City, Province, Postal Code

Telephone Number:

Email Address:

Emergency contact name: Phone:

Date:	**Refer to:** - BC Epilepsy Society Mental Wellness Program
Referring physician/source:	**Referring Prac ID:**
Address:	**Phone:**
	Fax:
Family physician:	**Family Prac ID:**
Specialist seen previously & when:	**Prior hospital admissions:** (past 2 years) - **Site(s)** _____ Currently hospitalized where _____

What is the patient being referred for? Please check all that apply:

- ☐ Anxiety
- ☐ Depression
- ☐ Depression
- ☐ Caregiver Support
- ☐ Family Support
- ☐ Difficulty adjusting to diagnosis
- ☐ Other, please specify below:

Diagnosis:	**Date of diagnosis:** (if known)

Please list any other diagnoses the patient has other than epilepsy below:

Questions for Physician Section:

Does the patient have suicidal ideations?

□Yes
□No
If Yes, please specify: _____

Does the patient have severe cognitive difficulties and/or intellectual difficulties and/or developmental delay?

□Yes
□No
If Yes, please specify: _____

Does the patient have a prominently presenting personality disorder?

□Yes
□No
If Yes, please specify: _____

Does the patient have a history substance use and/or addiction?

□Yes
□No
If Yes, please specify: _____

Criteria for the Program:

1) The person being referred has a diagnosis of epilepsy or is an immediate family member of a person living with epilepsy.
2) The person being referred has a epilepsy-related purpose to seek counselling.
3) The person being referred may also have a concurrent diagnosis of functional seizures

Signature: _____ **Designation:** _____ **Date:** _____