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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Name** | **Patient Phone #** | | | **Alt. Phone #** | | | |
| **Parent/Guardian Name** | **Parent Phone #** | | | **Alt. Phone #** | | | |
| ❑**This Communication Plan has been discussed with Child/youth** ❑**Discussed with Parent/Guardian** | | | | | | | |
| **Presenting concern (s) as reported by patient** | | | | | | | |
|  | | | | | | | |
|  | | | | | | | |
| **Discharge impressions and recommendations** | | | | | | | |
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| **Strategies for Parent/Guardian:** ❑ Return to ED ❑ Review Safety Plan ❑ Follow-up with GP/FP/NP | | | | | | | |
| **Medications at the time of discharge (current/new)** | | | | | | | |
| ❑**Continue current medications as per Medication Reconciliation (attached)** | | | | | | | |
| Medication Name | | Dosage/Duration | | Prescription Written | | | Duration |
|  | |  | | ❑Yes | ❑No | |  |
|  | |  | | ❑Yes | ❑No | |  |
|  | |  | | ❑Yes | ❑No | |  |
| **Community Follow-up Details** | | | | | | | **Date Faxed** |
| **Child Youth Mental Health Clinic** Phone: **250-992-4267** Fax: **250-992-4351**  ❑ Client was asked to attend **the first** *CYMH Walk in Clinic*  ❑ CYMH Walk In Clinic brochure provided  ❑ Urgent contact by CYMH required ( < 2 business days)  ❑ Has an existing CYMH clinician, name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ❑ Communication Plan faxed to CYMH | | | | | | |  |
| ❑ **Family Physician/NP** Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Communication Plan Faxed  ❑ Family *is aware* to arrange appointment in\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_day | | | | | | |  |
| ❑ **Substance Use Services:** Communication Plan faxed (follow up required < 2 business days) | | | | | | |  |
| **Youth Outreach & Family Support Workers**  Communication Plan faxed to:  ❑**Friendship Center** Fax: **250-992-5708**  ❑**Nazko** Fax: **250-249-6021** ❑**North Cariboo Metis** Fax: **250-992-9721**  ❑**Red Bluff** Fax: **250-747-1341**❑**Kluscus** Fax:**250-992-3291** ❑**Alexandria** Fax: **250-747-3920** ❑**Carrier Chilcotin Tribal Council** Fax: **250-992-2075** | | | | | | |  |
| Other: | | | | | | |  |
| Physician/clinician/Nurse Name (print) | | | Physician/Clinician/Nurse signature | | | | |
| Designation | | | Contact information | | | Date | |