

PSYCHIATRY REFERRAL FORM

- * Attach a copy of completed Master Problem List, complete Med List and recent (last 6-12 mos) labs
- * Attach last two (pertinent) medical visit notes * Attach current database
- * Attach BH Patient Intake, BH Intake Summary, and last two BH visit notes (if done within one year)
- * Attach any other (pertinent) psychiatric consult notes

Client Name: _____ DOB: _____ MR #: _____
Referring Provider: _____ Date: _____
 DNCHC ECHC HODC MCHC NCC Current Phone #: _____

REASON FOR REFERRAL: Med Mgmt Med Consult (one time visit) Diagnostic Opinion
SIGNS AND SYMPTOMS: Anger/Aggression Impulsivity Mood/Anxiety Psychosis Other: _____
CLINICAL QUESTION/CONCERN: _____

HISTORY OF PRESENT ILLNESS: _____

RELEVANT SOCIAL HISTORY (brief):

- _____
- Substance use: N/A ETOH Heroin Amphetamine Prescription Drugs Cocaine Nicotine Caffeine
 Marijuana Other: _____
 - Criminal/Justice: N/A _____

PSYCH MEDS:

<u>Current Meds</u> <input type="checkbox"/> Med List has been updated				<u>Past Meds</u>			
<u>Name of Medication</u>	<u>Dose</u>	<u>Duration</u>	<u>Effects</u>	<u>Name of Medication</u>	<u>Dose</u>	<u>Duration</u>	<u>Effects</u>
1. _____				1. _____			
2. _____				2. _____			
3. _____				3. _____			
4. _____				4. _____			
5. _____				5. _____			
6. _____				6. _____			
7. _____				7. _____			

PAST PSYCHIATRIC HISTORY:

- Psychiatric outpatient care: N/A Current: HCMH DNCMH _____
- Psychiatric hospitalizations: N/A _____
- Suicide attempts: N/A _____
- Family psychiatric history: N/A _____

PAST MEDICAL HISTORY:

- Yes No Allergies: NKDA _____
- Yes No Head trauma, developmental disability, seizure disorder: _____
- Yes No Liver disease: Hepatitis: viral / ETOH / non-alcoholic steatohepatitis / fatty cirrhosis interferon treatment
Other: _____
- Yes No Renal disease: insufficiency failure dialysis other: _____
- Yes No Heart disease: CAD hypertension arrhythmias, type: _____ other: _____
- Yes No Metabolic disease: metabolic syndrome glucose intolerance hyperlipidemia other: _____
- Yes No Thyroid disease: hypo hyper other: _____
- Yes No Diabetes: type 1 type 2 insulin requiring controlled uncontrolled other: _____
- Yes No Possibility of pregnancy? Unknown Birth control? _____

PCP Signature: _____ Patient Scheduled: (Date and Time) _____
Referring Site Coord: _____ Not Scheduled: Unable to contact Patient declines services

CONFIDENTIAL