Child Psychiatry Consultation Clinic Referral Form

617 Riverside Avenue Burlington, VT 05401 Phone: (802) 864-6309 Fax: (802) 540-8977 www.chcb.org

Patient Information

NAME:_______________________________________
DOB: ____
PARENT/GUARDIAN NAME(S):___________________
____
ADDRESS: ___________________________________
HOME PHONE NUMBER:_________________________
WORK PHONE NUMBER:_________________________

INSURANCE CARRIER:__________________________
Policy#______________Group#___________________
POLICY HOLDERS NAME:_______________________
INSURANCE ADDRESS:_________________________
INSURANCE PHONE: __________________________

Referring Provider Information

PROVIDER NAME:_______________________________
PROVIDER PRACTICE NAME:_______________________
PROVIDER ADDRESS:___________________________
____
PROVIDER PHONE NUMBER:_______________________
PROVIDER/PRACTICE EMAIL ADDRESS:_______________
PROVIDER FAX NUMBER:_________________________

Patient Information:

☐ I, the referring provider, understand that this is a referral for a Psychiatric Consultation, and NOT ongoing treatment and medication management and/or prescribing.

☐ I, the referring provider, understand that the CPCC is not designed for urgent assessment of children and adolescents with acute safety concerns. Please contact your local Community Mental Health Center if needed for any urgent safety concerns.

WHAT IS THE KEY QUESTION YOU WOULD LIKE ADDRESSED WITH THIS CONSULTATION?
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PRESUMPTIVE PSYCHIATRIC DIAGNOS(ES) AND MOST PERTINENT SYMPTOMS:
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PERTINENT PAST MEDICAL/PSYCHIATRIC HISTORY INCLUDING PAST PSYCHIATRIC MEDICATION TRIALS:

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PLEASE LIST ANY OTHER TREATMENT PROVIDERS/AGENCIES INVOLVED:

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CURRENT MEDICATIONS:

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PLEASE SEND THIS COMPLETED FORM, ALONG WITH THE FOLLOWING, TO CPCC@CHCB.ORG.

- Pertinent Medical Records (including ASEBA's if completed, etc.)
- Completed CPCC Disclosure to CHCB Form (ROI)
- Completed CPCC Disclosure to Medical Home Form (ROI)
- CPCC Consultation Patient Agreement form signed by parent/guardian

Once these five items are received by the CHCB Child Psychiatry Consultation Clinic, an appointment will be scheduled.

☐ *Please check here, email us at CPCC@CHCB.org,or fax to 802-540-8977 if the referring provider would like to attend part of the Psychiatric evaluation, either in person, via phone, or via ZOOM video, and you will be contacted with the appointment time and how to attend or call in.*

REFERRING PROVIDER SIGNATURE: ___________________________________ DATE: __________ TIME: __________