Child Psychiatry Consultation Clinic

Referral Form

617 Riverside Avenue Burlington, VT 05401 Phone (802) 540-8977 Fax (802) 540-6848 www.chcb.org

Patient Information

NAME: _____
PREFERED NAME: _____
PREFERED PRONOUN: _____
DOB: _____ ☐ BIPOC ☐ LBGTQ+
PARENT/GUARDIAN NAME(S): _____
_____
ADDRESS: _____
BEST CONTACT NUMBER: _____
EMAIL ADDRESS: _____
INSURANCE CARRIER: _____
Policy#_____ Group#_____
POLICY HOLDERS NAME: _____
POLICY HOLDERS DOB: _____

Referring Provider Information

PROVIDER NAME: _____
PRACTICE NAME: _____
PRACTICE ADDRESS: _____
_____
PRACTICE PHONE NUMBER: _____
PRACTICE FAX NUMBER: _____
PROVIDER/PRACTICE EMAIL: _____
***Please email CPCC@chcb.org using patient initials once the referral has been faxed to confirm receipt.**

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.

Which of the following is the primary reason for the referral?

☐Pharmacological Tx ☐Non Pharmacological Tx ☐Diagnostic clarification ☐Covid-19 PCP support

WHAT IS THE MAIN CONCERN YOU WOULD LIKE ADDRESSED WITH THIS CONSULTATION?

_____
_____
_____
_____

PRESUMPTIVE PSYCHIATRIC DIAGNOSES AND MOST PERTINENT SYMPTOMS:

_____
_____
_____
_____

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PAST PSYCHIATRIC HISTORY (psychiatry, therapy, ED visit, hospitalizations):

_____

_____

_____

_____

Psychiatrist: ☐ Yes ☐No ☐Don't know ☐In the past

Therapy/counseling: ☐ Yes ☐No ☐Don't know ☐In the past

Other mental health services: ☐ Yes ☐No ☐Don't know ☐In the past

CURRENT MEDICATIONS (psychiatric and medical):

_____

_____

_____

_____

PAST PSYCHIATRIC MEDICATION:

_____

_____

_____

_____

PERTINENT PAST MEDICAL HISTORY:

_____

_____

_____

_____

PLESE LIST ANY OTHER TREATMENT PROVIDERS/AGENCIES INVOLVED:

_____

_____

_____

_____

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Patient Information:

Has the child received psychiatric inpatient services in the last 3 month? ☐ Yes ☐No ☐Don't know

Has the child gone to psychiatric ER/hospital in the last 3 months? ☐ Yes ☐No ☐Don't know

Has the child received any other crisis services (911, crisis eval) in the last 3 months? ☐ Yes ☐No ☐Don't know

Do you feel the child is at risk for hurting themselves or others? ☐ Yes ☐No ☐Don't know

If imminent please refer to your local crisis agency or ED.

Rating scale information:

Are there any completed rating scales available? ☐ Yes ☐No ☐Don't know

If Yes, check those scaled that are available:

☐CGAS ☐GAD-7 ☐PSC-Parent ☐PSC-Child ☐Vanderbilt ☐Vanderbilt-teacher ☐Scared ☐PHQ-9 ☐Other

Scores, if available, may be entered below:

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

- Pertinent Medical Records (including ASEBA's if completed, ect.)
- Completed CPCC Disclosure to CHCB form (ROI)
- Completed CPCC Disclosure to Medical Home Form (ROI)
- CPCC Concultation 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) 540-6848 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: _____