CHILD AND ADOLESCENT PSYCHIATRY REFERRAL REQUEST FORM

(Services are for patients aged 6-17 years old)

Phone: 361-694-1550 Fax: 361-808-2766

DATE REQUESTED ___ /___ /___

Please note, we do not provide psychotherapy at this time.

PATIENT DEMOGRAPHICS:

Patient's Name: _____ DOB: ___/___/___ ☐Male ☐Female

Responsible Party: _____ (mother/father/other)

Patient's Address: _____ City/State/Zip: _____

Best Contact Number:_____ Alternate Contact Number: _____

Interpreter Required? ☐ YES ☐ NO Language: _____

INSURANCE INFORMATION:

Primary Insurance: _____ Secondary Insurance: _____

Subscriber's Name: _____ Subscriber's Name: _____

ID# _____ Group #_____ ID#_____ Group #_____

Reason for Referral: _____

_____

Straightforward cases will be transitioned back to PCP to resume care. In the event referral is beyond scope of providers, PCP office will be notified.

Consultation with Psychiatrist

Please include with the referral these finding and previously administered services:

- Early Childhood Intervention
- Neurology
- Genetics
- School Based Services (504/ARD/IEP)
- Speech/OT/PT
- Previous therapy/Counseling (providers notes if possible)
- Previous Psychologist/Psychiatrist/Psychiatric Hospitalizations (providers notes if possible)

(CHECK ALL THAT APPLY) **PLEASE NOTE THAT REFERRALS FOR SUSPECTED PRIMARY DIAGNOSIS OF ADHD, ASD, OR INTELLECTUAL DISABILITIES SHOULD BE DIRECTED TO DEVELOPMENTAL PEDIATRIC MEDICINE**

□ Anxiety
□ Depression
□ Gender Dysphoria
□ Obsessive Compulsive Disorder
□ Second Opinion for diagnosis or treatment
□ Bipolar Disorder
□ Psychosis
□ Trauma

Suspected Diagnosis? _____

REFERRING PRACTICE INFORMATION

Referring Provider Name: _____(*Please print legibly*)

Practice Name: _____ Practice NPI#:_____

Address: _____Telephone: _____ Fax: _____

PLEASE INCLUDE DEMOGRAPHICS INFO, COPY OF INSURANCE (both sides)

& CURRENT CLINICALS and MEDICATION LIST