Psychiatric Referral Form

Instructions for referring professional: Please complete all of the following sections as thoroughly as possible. In addition to this Referral Form, please provide a current release of information, your initial intake assessment documentation, and any other treatment records you have that are relevant to this referral. Please note: We need to have all of these materials prior to scheduling a client’s initial appointment so the psychiatrist can review them before meeting with the client. Once these materials are received by the CAPS-PUSH office and reviewed by the psychiatry team the student will be contacted to schedule their initial psychiatry appointment.

Student’s Name: _______________________________________ Student’s PUID: ______________________

I. Summary of Current Treatment

Length of treatment

Beginning date: ___________ End date: ___________ Number of appointments: ___________
Frequency of appointments: ___________________________________________________________
Comments: ___________________________________________________________________________

Focus of current work with student (please be specific): _______________________________________

II. Reason for Referral to Psychiatry at this time (please be specific):

_____________________________________________________________________________________

III. Assessment of Current Functioning

Presenting Problem (duration, frequency, and history of symptoms): ____________________________

_____________________________________________________________________________________

Unless specified in your initial intake assessment documentation, please address the following:
### History and Relevant Information:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Current outpatient treatment?</td>
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<td>Past outpatient treatment (including group)?</td>
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<td>Past psychiatric hospitalization?</td>
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<td>Current thoughts of harming self or anyone else?</td>
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<td>Past suicide attempt or intentional self-harm?</td>
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<td>Concerns with use of alcohol or other drugs?</td>
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<td>Involved in any legal or judicial proceedings?</td>
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<td>Concerns about appetite, eating behaviors, weight, or body image?</td>
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<td>Sleep problems?</td>
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<td>Medical Problems/Diagnoses?</td>
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<td>Current Medications?</td>
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<td>Prescribed by?</td>
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**Comments (If yes, please explain thoroughly):**

Assessment of Risk, including type of assessment conducted, when it was conducted, level of risk and findings/results/plans developed (please be specific):

___________________________________________________________

_______________________________

Students’ Resources/Strengths: ____________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

Specific concerns you have about this student: _______________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

**Your Clinical Impressions, Insights and Observations:**

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

III. Additional Information Relevant to Student’s Case

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

Thank you for this referral. Please fax this form, along with a current release of information, your initial intake assessment documentation and any other relevant records to CAPS at (765) 496-2139, or mail them in, attn.: Erin Perry, RN. It is our expectation that following the initial appointment with CAPS Psychiatry that we will continue to collaborate around client care. We look forward to working with you!

Signature of Referral Source:__________________________ Date:______________

Office Location:____________________________________________________

Office Phone Number:_________________________________________