PURDUE UNIVERSITY

COUNSELING AND PSYCHOLOGICAL SERVICES (CAPS)

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: **Comments** (If yes, please explain thoroughly):

Current outpatient treatment? ☐ Yes ☐ No _____
Past outpatient treatment (including group)? ☐ Yes ☐ No _____
Past psychiatric hospitalization? ☐ Yes ☐ No _____
Current thoughts of harming self or anyone else? ☐ Yes ☐ No _____
Past suicide attempt or intentional self-harm? ☐ Yes ☐ No _____
Concerns with use of alcohol or other drugs? ☐ Yes ☐ No _____
Involved in any legal or judicial proceedings? ☐ Yes ☐ No _____
Concerns about appetite, eating behaviors, weight, or body image? ☐ Yes ☐ No _____
Sleep problems? ☐ Yes ☐ No _____
Medical Problems/Diagnoses? ☐ Yes ☐ No _____
Current Medications? ☐ Yes ☐ No _____
Prescribed by? _____

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: _____

IIII. 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: _____

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PSYC ■ 601 Stadium Mall Drive ■ West Lafayette, IN 47907-2052 ■ (765) 494-6995 ■ Fax: (765) 496-2139