

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:**

- 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? \_\_\_\_\_

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

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

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*Students' Resources/Strengths:* \_\_\_\_\_

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*Specific concerns you have about this student:* \_\_\_\_\_

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

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**III. Additional Information Relevant to Student's Case**

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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: \_\_\_\_\_