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| Division of Child & Family Guidance & Consultation601 Children’s LaneNorfolk, VA 23507757.668.8866 (Messages Are Confidential)757.668.8870 FaxEmail: psychiatry@chkd.org | Peter M. Dozier, M.D., Director Mary D. Kittle, PMHNPJames F. Paulson, Ph.D., PsychologistDiana W. Schofield, Psy.D., Psychologist Takeshia V. Williams, Ph.D, Psychologist Renauda Lewis, Practice ManagerDebbie Hurt, Office CoordinatorJennifer Barger, Medical Office Technician |

CHKD health system logo |  |

# Child & Family Guidance & Consultation (CFGC) Referral Form

## Referral Guidelines

1. To refer your patient for consultation, please complete this form and return it, along with the most recent visit note or supporting documentation related to the patient’s psychiatric needs.
2. **We only review forms completed in their entirety.**
3. We strive to answer all referrals in writing to the referral source within 5-10 business days. It is the referring physician’s responsibility to relay decisions and information to patients.
4. Our division does not provide emergency care.

## Referral Data

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| --- | --- | --- | --- | --- |
| Referring Physician: |  |  | Date: |  |
| Practice Name: |  |  | Phone: |  |
| Office Contact: |  |  | Fax: |  |

## Patient Information

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| Patient Name: |  |  | City/State of Residence: |  |
| Gender: |  |  | Caregiver Name: |  |
| Age: |  |  | Phone: |  |
| Insurance Provider: |  |

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| Have you referred this patient to any other mental health service within the past 6 months (e.g. Developmental Pediatrics, Behavioral Health, Neurology)? |
| [ ]  Yes, another CHKD department:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Yes, a community agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  No |

## Defining Your Patient’s Needs

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| 1. Does the patient have a suspected comorbidity of at least 2 major psychiatric disorders OR is the patient under the age of 5 with a suspected psychiatric disorder?
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|  [ ] Yes, the patient has the following suspected psychiatric diagnoses:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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 [ ] No, the patient does not meet this criteria ***If your response is no:*** Given the limited resources in our division, our services are directed at children with complex  psychiatric presentations and the preschool population. Please feel free to contact us for guidance with medication  management or community referrals. |

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| 1. Is the **primary** concern for this child a diagnosis of Autism Spectrum Disorder or another developmental disorder?
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| [ ] Yes***If your response is yes:*** This patient may be better served by CHKD’s Developmental Pediatrics. Please contact Developmental Pediatrics (757) 668-7473 to inquire about their referral process.[ ] No |

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| 1. What psychotropic medications have been trialed?

 **Prescribed By:** |
| * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  You [ ]  Other
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  You [ ]  Other
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  You [ ]  Other

[ ] No psychotropic medications have been trialed with this patient.***If your response is no:*** Given that our services are directed at children who have not benefited or tolerated previous treatment efforts, please consider a phone or email consultation with our child psychiatrist, Dr. Peter Dozier, regarding selection and dosing of psychotropic medication. [ ]  Please check this box if you would like a phone or email consultation.Direct Office Number/ Mobile Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| 1. To your knowledge, what behavioral interventions have been attempted?
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| [ ] Individual or Family Therapy [ ] Psychological Evaluation [ ] 504 Plan or Individualized Education Plan (IEP) at school[ ] Psychiatric Inpatient/ Residential Care [ ] If no behavioral interventions have been attempted, please consider initiating before referral to our division as there is strong research evidence that children are most likely to benefit from pharmacologic support after they have started behavioral interventions. [ ] Check this box if you need assistance identifying local resources. Direct Office Number/ Mobile Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| 1. What specific questions or concerns can we address in providing this consultation?
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## IMPORTANT: Agreement Regarding Follow-Up Care

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| I understand that CFGC is a consultative service and does not provide ongoing psychiatric care for patients. At the completion of the psychiatric consultation, and after the patient’s condition is improved and stable, the referring practice is expected to manage this patient’s psychiatric medications (with ongoing support and consultation from CFGC). \_\_\_\_\_\_\_\_\_\_\_\_Your Initials |