**Psychiatric Consultation Referral Form for Community Therapists**

Name of client_____ Date of referral_____

Client's Phone #_____ Date of Birth_____

Referring clinician _____ Clinician's phone #_____

**Please attach your initial consultation note and recent progress notes and attach a detailed treatment summary that includes the following information:**

- **Presenting concern and recent course of treatment**
- **History of mental health symptoms and treatment including the following:**
    - **Significant substance use, eating or weight concerns, psychiatric consultation, psychiatric hospitalizations, current or history of suicidal, homicidal impulses or self-harming behaviors, any medications that client is currently taking and name of prescriber of the medication, medication trials, and significant physical/emotional /sexual abuse.**
- **Social/Developmental history**
- **Strengths, values, coping skills, interests, areas of life that are going well**
- **Physical health/medical history**
- **Summary, initial formulation and client goals**

Specific reason for referral: _____

What do you appreciate about this client? _____

_____

_____

**FAX this form and attachments to (413) 545-9602**
*Please use a cover letter and send to "ATTN: Bee Emily"*

Bee Emily, Psychiatric RN Referral Coordinator
Center for Counseling and Psychological Health
University of Massachusetts
voice: (413) 545-2337
fax: (413) 545-9602

**Once all of this information is received and reviewed, we will contact the student to schedule an initial psychiatric consultation.**