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? ____

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FAX or MAIL this form and attachments to:

Bee Emily, Psychiatric RN Referral Coordinator
Center for Counseling and Psychological Health
University of Massachusetts
111 County Circle
Middlesex Building
Amherst, MA 01003-9361

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.