UR MEDICINE | STRONG MEMORIAL HOSPITAL

MR#________________
(OFFICE USE ONLY)

CHILD AND ADOLESCENT PARTIAL HOSPITALIZATION SERVICE (CAPHS)

DEPARTMENT OF PSYCHIATRY

REFERRAL FORM

Phone (585) 273-1779 Fax (585) 273-1386

PATIENT: ______________________ DOB: ________ Age: _____ Gender: _____ Ethnicity: ________

Address: ____

City: ______________ State: ______________ Zip: __________ Phone #: ( ) ____________

School: ____________________ Regular Education / Special Education (circle one) Grade: __________

PARENT /GUARDIAN:

Name	Relationship to Patient	Home Number	Cell/Work Number

INSURANCE:

Coverage: ______________________ Contract #: ______________________

Primary Care Physician: ______________________ Phone #: ______________________

CLINICAL DATA:

Mental Health Diagnosis: ____

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Medical Concerns: ____

Psychosocial Stressors:
(Z Codes) ____

Has patient had any prior psychiatric hospitalizations? If yes, specify when and where: ______________________

____

RISK FACTORS:

	Current Episode	Past History
Affective instability	☐	☐
Alcohol/substance abuse	☐	☐
Anorexia	☐	☐
Anxiety	☐	☐
Bulimia	☐	☐
Depression	☐	☐
Eating problems	☐	☐
Encopresis / Enuresis	☐	☐
Hallucinations/delusions	☐	☐
Hyperactive/inattentive	☐	☐
Language processing/LD	☐	☐
Low cognitive functioning/MR	☐	☐
Oppositional/defiant	☐	☐
Physically assaultive	☐	☐

	Current Episode	Past History
Poor impulse control	☐	☐
Property destruction	☐	☐
School avoidance	☐	☐
School problems	☐	☐
Self-mutilation	☐	☐
Sexual acting out	☐	☐
Sleeping problems	☐	☐
Social withdrawal	☐	☐
Suicidal ideation	☐	☐
Suicide attempt	☐	☐
Temper outbursts	☐	☐
Thought disorder	☐	☐
Threatening	☐	☐

Referral must be accompanied by a copy of a current clinical summary and a signed release of information form.

PLEASE PRINT CLEARLY OR TYPE:

PSYCHOTROPIC MEDICATIONS: (Past Trials/ Current Regimen)

Medication	Dosage	Target Symptoms	Response	Start Date	End Date

DOES THE PATIENT HAVE DIABETIES/ASTHMA OR ANY OTHER MEDICAL ISSUE? ☐Yes ☐No

If yes, what is the medical issue and who are the providers? ____

CPS/ LEGAL INVOLVEMENT: ____

____

GROUP EXPERIENCE: How does the patient do in group? ____

PATIENT'S CHIEF COMPLAINT: ____

THERAPIST/PROVIDERS REASON FOR REFERRAL: ____

____

____

____

CURRENT TREATMENT PROVIDERS:

Therapist:

Name:		Phone Number:		Fax Number:	
Address:				Duration:	

Psychiatrist:

Name:		Phone Number:		Fax Number:	
Address:				Duration:	

Case Manager/Other:

Name:		Phone Number:		Fax Number:	
Address:				Duration:	

REFERRING PERSON: ______________________________ Phone #: (   ) ______________________

Address: ______________________________ Agency/Program: ______________________________

Is the patient in agreement with the referral? ☐Yes ☐No

Referral must be accompanied by a copy of a current clinical summary and a signed release of information form.