**Referral for Medication Evaluation**

Referral Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ For internal use only ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CAPS ◻ UHS ◻

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth or ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# of psychotherapy sessions in current course of treatment prior to referral: \_\_\_\_\_\_\_\_\_\_

Relevant History and Reason for Referral:

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Risk Assessment (all information required):

1. SI (current): ◻Yes ◻No ◻Not Assessed
2. SI (past): ◻Yes ◻No ◻Not Assessed
3. Previous suicide attempts: ◻Yes ◻No ◻Not Assessed

If yes, please describe (including dates): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. SIB/NSSI (past or current): ◻Yes ◻No ◻Not Assessed
2. Harm to others (past or current): ◻Yes ◻No ◻Not Assessed

If yes, please describe (including dates): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Previous Partial or Inpatient hospitalization: ◻Yes ◻No ◻Not Assessed

If yes, please describe (including dates): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Substance abuse or dependence (past or current): ◻Yes ◻No ◻Not Assessed
2. Eating concerns or disorder (past or current): ◻Yes ◻No ◻Not Assessed

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Current Psychiatric Medications (include: drug names, dosage, prescriber, date started):

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Current Diagnosis (DSM-V or ICD-10):

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Target Symptoms:

|  |
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Psychotherapy Follow-Up Plan:

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**Provider Information**

Referring Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are an off-campus provider, what number can we call if there are urgent needs with the student and we need to have you involved, even if after hours: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*this should be a way to reach you specifically, not a local/national hotline*

Referring Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_