## H&W Referral for Medication Evaluation

**Email completed form to counseling@health.brown.edu or fax to 401-863-3675**

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): ___________________________________

4. SIB/NSSI (past or current): ☐Yes ☐No ☐Not Assessed
5. Harm to others (past or current): ☐Yes ☐No ☐Not Assessed

   If yes, please describe (including dates): ___________________________________

6. Previous Partial or Inpatient hospitalization: ☐Yes ☐No ☐Not Assessed If yes, please describe (including dates): ___________________________________

7. Substance abuse or dependence (past or current): ☐Yes ☐No ☐Not Assessed 8. Eating concerns or disorder (past or current): ☐Yes ☐No ☐Not Assessed 9. Financially limited in seeking community psychiatrist: ☐Yes ☐No ☐Not Assessed 10. Treatment plan includes therapy: ☐Yes ☐No

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

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

Target Symptoms:

Psychotherapy Follow-Up Plan:

☐ Will see ____________________ for ☐ regular therapy ☐ as needed for increased symptoms

**Provider Information**

Referring Provider Name: __________________________________

Business Phone: ____________________

Referring Provider Signature: __________________________________