



Student Health and Wellness Referral for Medication Evaluation

To be completed by your therapist (CAPS, TimelyCare or Community provider) and emailed to counseling@health.brown.edu or faxed to **401-863-3657**.

Section One: Referral Information

Referral Date: _____
Student Name: _____
Date of Birth or ID #: _____
Number of sessions in current course
of treatment prior to referral: _____

For internal use only ID # _____ ☐ Student Health Services

Relevant History and Reason for Referral:

Section Two: 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

Section Three: Details (required)

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

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

*Please note, if a student is seeking medication management for ADHD, Brown requires a copy of neuro-psychiatric testing (preference), or a letter or copy of the most recent visit note from the prescriber who is currently treating the student, specifying current (required) and previous medication trials (preferred).

Target Symptoms:

Section Four: Provider Information

Referring Provider Name: _____
Business Phone: _____
Referring Provider Signature: _____

Psychotherapy Follow-Up Plan: ☐ Will See: _____
☐ For regular therapy ☐ As needed for increased symptoms