BROWN
Campus Life

Counseling and Psychological Services
450 Brook St, Box 1960
Providence, RI 02912
Phone: 401-863-3476
Fax: 401-863-3657

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. Eatting 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

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