MR#_____
(OFFICE USE ONLY)

CHILD AND ADOLESCENT PARTIAL HOSPITALIZATION SERVICE (CAPHS)

DEPARTMENT OF PSYCHIATRY

REFERRAL FORM

Phone (585) 273-1779 Fax (585) 273-1386
Email - ChildandAdolescentPartialIntakeTeam@URMC.Rochester.edu

PATIENT: _____ DOB: _____ Age: _____ Gender: _____ Ethnicity: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

School: _____ Special Education? _____ Grade: _____

PARENT /GUARDIAN:

Name	Relationship to Patient	Home Number	Work Number

INSURANCE:

Coverage: _____ Contract #: _____

Primary Care Physician: _____ Phone #: _____

CLINICAL DATA:

Mental Health Diagnosis: _____

Mental Health Diagnosis: _____

Medical Concerns: _____

Psychosocial Stressors:
(Z Codes) _____

Has patient had any prior psychiatric hospitalizations? If yes, specify when & where: _____

_____

_____

RISK FACTORS:

	Current Episode	Past History		Current Episode	Past History
Affective instability	☐	☐	Poor impulse control	☐	☐
Alcohol/substance abuse	☐	☐	Property destruction	☐	☐
Anorexia	☐	☐	School avoidance	☐	☐
Anxiety	☐	☐	School problems	☐	☐
Bulimia	☐	☐	Self-mutilation	☐	☐
Depression	☐	☐	Sexual acting out	☐	☐
Eating problems	☐	☐	Sleeping problems	☐	☐
Encopresis / Enuresis	☐	☐	Social withdrawal	☐	☐
Hallucinations/delusions	☐	☐	Suicidal ideation	☐	☐
Hyperactive/inattentive	☐	☐	Suicide attempt	☐	☐
Language processing/LD	☐	☐	Temper outbursts	☐	☐
Low cognitive functioning/MR	☐	☐	Thought disorder	☐	☐
Oppositional/defiant	☐	☐	Threatening	☐	☐
Physically assaultive	☐	☐	Poor impulse control	☐	☐

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 DIABETES /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 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.