



UR  
MEDICINE

GOLISANO  
CHILDREN'S HOSPITAL



MR# \_\_\_\_\_  
(OFFICE USE ONLY)

# CHILD AND ADOLESCENT PARTIAL HOSPITALIZATION SERVICE (CAPHS)

DEPARTMENT OF PSYCHIATRY

## REFERRAL FORM

Phone (585) 273-1779 Fax (585) 273-1386

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	<input type="checkbox"/>	<input type="checkbox"/>	Poor impulse control	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	Property destruction	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	School avoidance	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	School problems	<input type="checkbox"/>	<input type="checkbox"/>
Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	Self-mutilation	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Sexual acting out	<input type="checkbox"/>	<input type="checkbox"/>
Eating problems	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping problems	<input type="checkbox"/>	<input type="checkbox"/>
Encopresis / Enuresis	<input type="checkbox"/>	<input type="checkbox"/>	Social withdrawal	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations/delusions	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal ideation	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactive/inattentive	<input type="checkbox"/>	<input type="checkbox"/>	Suicide attempt	<input type="checkbox"/>	<input type="checkbox"/>
Language processing/LD	<input type="checkbox"/>	<input type="checkbox"/>	Temper outbursts	<input type="checkbox"/>	<input type="checkbox"/>
Low cognitive functioning/MR	<input type="checkbox"/>	<input type="checkbox"/>	Thought disorder	<input type="checkbox"/>	<input type="checkbox"/>
Oppositional/defiant	<input type="checkbox"/>	<input type="checkbox"/>	Threatening	<input type="checkbox"/>	<input type="checkbox"/>
Physically assaultive	<input type="checkbox"/>	<input type="checkbox"/>			

**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 DIABETIES/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.**