

BEHAVIORAL HEALTH REFERRAL / RESPONSE DOCUMENTATION

For use of this form see MEDCOM Circular 40-13

DATE OF REQUEST**SECTION I - PRIMARY CARE CLINIC REFERRAL to BEHAVIORAL HEALTH****PART A - REASON for REFERRAL****Evaluation and Treatment:** (Check all that apply)

- Medication
 Psychological Testing
 Psychotherapy
 Group Therapy
 Family Therapy
 Marital Counseling
 Other: _____

Advice for Treatment: (Check all that apply)

- Capacity for Management in the Primary Care Setting
 Initial Medication Recommendation
 Medication Failure
 Side Effects from Current Medication
 Life-style Modification Plan
 Resource Identification
 Other: _____

PART B - MEDICAL PROBLEMS and DEPRESSION ASSESSMENT**Relevant Medical Findings:**

Allergies: _____ Support System: _____

Depression Assessment: (Check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Feeling Down, Empty, Hopeless | <input type="checkbox"/> Sleep Disturbance (___ hrs/night) | <input type="checkbox"/> Weight Loss (___ lbs in ___ weeks) |
| <input type="checkbox"/> Loss of Interest or Pleasure | <input type="checkbox"/> Decreased Appetite | <input type="checkbox"/> Weight Gain (___ lbs in ___ weeks) |
| <input type="checkbox"/> Worthlessness, Guilt | <input type="checkbox"/> Increased Appetite | <input type="checkbox"/> Past Use of Psychotropic Medication |
| <input type="checkbox"/> Poor Concentration | <input type="checkbox"/> Danger to Self/Others | <input type="checkbox"/> Past History of Depression |
| <input type="checkbox"/> Poor Energy | <input type="checkbox"/> Drug Misuse/Abuse | <input type="checkbox"/> Past Psychiatric Hospitalization |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Periods of Hyperactivity/Excitability | <input type="checkbox"/> Other: _____ |

Diagnosis: _____ PRIME-MD SCORE: _____ CAGE-AID SCORE: _____

PART C - MENTAL STATUS ASSESSMENTDocument as indicated, or if N/A**Examples**

- | | | |
|-----------------------------------|--------------------------|--|
| Appearance: _____ | <input type="checkbox"/> | (appearance to age, dress, hygiene, grooming) |
| Speech: _____ | <input type="checkbox"/> | (volume, rate, clarity) |
| Response to Interview: _____ | <input type="checkbox"/> | (cooperative, frightened, distrustful, hostile, etc) |
| Mood / Affect: _____ | <input type="checkbox"/> | (euthymic, anxious, flat, tearful, blunted, etc) |
| Sensorium: _____ | <input type="checkbox"/> | (time, person, place, situation) |
| Thought Coherence: _____ | <input type="checkbox"/> | (logical, goal directed, tangential, loose associations) |
| Delusions / Hallucinations: _____ | <input type="checkbox"/> | (paranoid, grandiose) / (auditory, visual, tactile) |
| Suicide / Homicide: _____ | <input type="checkbox"/> | (ideation, intent w plan, means, pt/family history) |
| Intelligence: _____ | <input type="checkbox"/> | (below average, average, above average) |

PART D - CURRENT MEDICAL TREATMENT

All Current Medications/Herbals/Supplements (amount & dose): _____

Current Interventions: _____

Other: _____

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

Signature of Primary Care Manager / Date

Clinic: _____

Telephone: _____

SECTION II - BEHAVIORAL HEALTH RESPONSE

PART A - DIAGNOSTIC IMPRESSION

PART B - TREATMENT PLAN

<p>MEDICATION: (Check and describe all that apply)</p> <p><input type="checkbox"/> Antidepressant Medications:</p> <p><input type="checkbox"/> Other Medications:</p>	<p>INTERVENTION: (Check and describe all that apply)</p> <p><input type="checkbox"/> Psychological Testing</p> <p><input type="checkbox"/> Cognitive Behavioral Therapy</p> <p><input type="checkbox"/> Interpersonal Psychotherapy</p> <p><input type="checkbox"/> Brief Dynamic Psychotherapy</p> <p><input type="checkbox"/> Group Therapy</p> <p><input type="checkbox"/> Family Therapy</p> <p><input type="checkbox"/> Marital Counseling</p> <p><input type="checkbox"/> Other: _____</p> <p>Frequency: _____</p> <p>Anticipated Length of Treatment: _____</p>
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PART C - PATIENT EDUCATION

Patient Response to Plan: _____

Medication Information: _____ Disease Management Information: _____

Appointment Schedule: _____ Other: _____

PART D - CONTINUATION of CARE RECOMMENDATIONS

RECOMMENDATIONS TO PCM:

PCM Clinic Follow-up Appointments: _____

Indications for Referral Back to Behavioral Health: _____

Medication Adjustment: _____

Laboratory Studies: _____ Other: _____

<p>PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)</p> <div style="border: 1px solid black; height: 100px;"></div>	<p style="text-align: center;">_____ <i>Signature of Behavioral Health Specialist / Date</i></p> <p>Clinic: _____</p> <p>Telephone: _____</p>
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NOTE: At Conclusion or Discontinuation of Therapy Please Notify the Patient's PCM.