**CHILD & ADOLESCENT PSYCHIATRIC CONSULTATION CLINIC**

1. **Defining Who We See:**
	* Suspected comorbidity of at least 2 major psychiatric disorders (e.g., ADHD & Anxiety)
	* Suspected or diagnosed Bipolar Disorder or Schizophrenia
	* Any psychiatric disorder which has not responded to adequate treatment efforts
	* Any psychiatric disorder in a child 2-5 years old.
2. **Follow-up Care – Check Yes No**

After completion of our psychiatric consultation, will your practice be willing to manage this child’s psychiatric medications, given the following circumstances?

1. The child’s condition is improved & stable 3. We are available for advice
2. Psychotropic medications are stable 4. We will re-consult at your request

 **3. What therapy interventions have been accepted?**

* Psychotropic Medications
* Psychiatric Inpatient / Residential Care
* None
* Individual / Family Therapy

 **4.** **Please estimate allowable wait time (We do not provide emergency care)**

* Can wait 8 weeks or more
* Should be seen in 4 to 8 weeks (We will attempt but cannot guarantee an appointment)

 **5. Referral Data**

|  |  |
| --- | --- |
| Referring Physician: | Child’sName: |
| Practice Name: |  Girl Age: DOB: Boy |
| OfficeAddress: | Race/Ethnicity/Preferred language: |
| Phone: | ParentName(s): |
| Fax: | Parent address:Parent phone: |

**7. What questions can we address in providing the consultation?**

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**8. Please fax the completed form to 806-743-2784**

FOR OFFICE USE ONLY

APPT DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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