



Child Psychiatry Consultation Clinic Referral Form

617 Riverside Avenue

Burlington, VT 05401

Phone: (802) 864-6309

Fax: (802) 540-6848

www.chcb.org

Patient Information

NAME: _____

DOB: _____

PARENT/GUARDIAN NAME(S): _____

ADDRESS: _____

HOME PHONE NUMBER: _____

WORK PHONE NUMBER: _____

INSURANCE CARRIER: _____

Policy# _____ Group# _____

POLICY HOLDERS NAME: _____

INSURANCE ADDRESS: _____

INSURANCE PHONE: _____

Referring Provider Information

PROVIDER NAME: _____

PROVIDER PRACTICE NAME: _____

PROVIDER ADDRESS: _____

PROVIDER PHONE NUMBER: _____

PROVIDER/PRACTICE EMAIL ADDRESS: _____

PROVIDER FAX NUMBER: _____

Patient Information:

I, the referring provider, understand that this is a referral for a Psychiatric Consultation, and NOT ongoing treatment and medication management and/or prescribing.

I, the referring provider, understand that the CPCC is not designed for urgent assessment of children and adolescents with acute safety concerns. Please contact your local Community Mental Health Center if needed for any urgent safety concerns.

WHAT IS THE KEY QUESTION YOU WOULD LIKE ADDRESSED WITH THIS CONSULTATION?

PRESUMPTIVE PSYCHIATRIC DIAGNOS(ES) AND MOST PERTINENT SYMPTOMS:



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PERTINENT PAST MEDICAL/PSYCHIATRIC HISTORY INCLUDING PAST PSYCHIATRIC MEDICATION TRIALS:

PLEASE LIST ANY OTHER TREATMENT PROVIDERS/AGENCIES INVOLVED:

CURRENT MEDICATIONS:

PLEASE SEND THIS COMPLETED FORM, ALONG WITH THE FOLLOWING, TO CPCC@CHCB.ORG.

- Pertinent Medical Records (including ASEBA's if completed, etc.)
- Completed CPCC Disclosure to CHCB Form (ROI)
- Completed CPCC Disclosure to Medical Home Form (ROI)
- CPCC Consultation Patient Agreement form signed by parent/guardian

Once these five items are received by the CHCB Child Psychiatry Consultation Clinic, an appointment will be scheduled.

Please check here, email us at CPCC@CHCB.org, or fax to 802-540-6848 if the referring provider would like to attend part of the Psychiatric evaluation, either in person, via phone, or via ZOOM video, and you will be contacted with the appointment time and how to attend or call in.

REFERRING PROVIDER SIGNATURE: _____ DATE: _____ TIME: _____