# Behavioral Health Consultation Referral

Patient Name: _____ DOB: _____ Date: _____

Med Rec #: _____ Referral to: ☐ PCC ☐ Psychiatrist ☐ Psychotherapy ☐ CSS / MH

Phone #: _____ Referred by *(Provider)*: _____

*Please Evaluate or Follow-up with Patient for: (Check as many boxes as apply)*

| **Depression** | **Anxiety** | **Mood/Behavior Problems** | **Substance Abuse *(Specify)*** |
|---|---|---|---|
| ☐ Problem Coping c Depression *(Specify)* | ☐ Problem Managing Anxiety *(Specify)* | ☐ Peer Relational Conflicts | ☐ EHOH |
| ☐ Situational Depressed Mood | ☐ Panic Attacks | ☐ Sleep Problems | ☐ Marijuana |
| ☐ Functional Impairment | ☐ Related to Specific Situations | ☐ Attention Problems | ☐ Nicotine |
| ☐ Hx of Mania (Bipolar) | ☐ Generalized | ☐ Impulsivity/ Hyperactivity / Restlessness | ☐ Caffeine |
| ☐ Suicidal Ideation | ☐ Obsessive/Compulsive Behavior | ☐ Anger Control Problems | ☐ Amphetamines |
| ☐ Issues of Loss/Bereavement | ☐ Related to Trauma (i.e., PTSD) | ☐ Child Abuse/Neglect | ☐ Opiates |
| | | ☐ Sexual Abuse/Assault *(Specify)* | ☐ Prescription Medications |
| | | ☐ Victim ☐ Perpetrator | ☐ Over the Counter Medications |
| | | ☐ Irritability/Agitation | ☐ Inhalants |
| | | ☐ Other | ☐ Other |
| **Psychosis** | **Adjustment Problems** | **Medical-Related Issues** | **Pregnancy *(Specify)*** |
| ☐ Auditory Hallucinations | ☐ Acculteration / New Arrival Issues | ☐ Chronic Pain/Illness, Fibromyalgia, CFS | ☐ Prevention |
| ☐ Visual Hallucinations | ☐ Problems Accessing Services | ☐ Diabetes Issues | ☐ Unwanted |
| ☐ Delusions (Bizarre / Irrational Beliefs) | ☐ Homelessness | ☐ Medication Adherence Issues | ☐ Fetal Death |
| ☐ Disorganized Speech / Behavior | ☐ Financial Problems | ☐ Traumatic Brain Injury | ☐ Teen |
| | ☐ Work-Related Stress | ☐ Memory Problems / Dementia | ☐ Related Emotional Problems |
| | ☐ Joblessness / Termination Issues | ☐ Other | |
| **Sexual Issues** | **Relationship / Family Issues** | **Childhood** | **Eating / Control Issues** |
| ☐ Sexual Dysfunction | ☐ Parenting Issues | ☐ Child Behavior Problems | ☐ Eating Disorder (i.e., Bulimia) |
| ☐ Problem c Sex Interest / Communication | ☐ Relationship / Couples Problems | ☐ Enuresis / Encropresis | ☐ Change in Appetite |
| | ☐ Domestic Violence | ☐ Communication Issues (i.e., withdrawal) | ☐ Over Eating |
| | | ☐ Developmental Learning D/O (i.e., MR) | ☐ Weight Gain / Loss |
| | | ☐ Somatic Complaints | |

Additional Concerns or Questions: _____

## Initial Behavioral Health Consultation Note

☐ Called Pt., Left Message: (Int. _____) ☐ Called Pt., No ans./ Busy: (Int. _____) ☐ Scheduled Appt. for ___/___/___

## Subjective / Objective:

**Mood:** ☐ Depressed ☐ Anxious ☐ Angry ☐ Elevated ☐ Irritable ☐ Normal
☐ SI/HI (specify) Plan:_____ Intent:_____ Si/Hi/At Hx:_____ ☐ Means:_____

**Affect:** ☐ Intact/Normal ☐ Constricted ☐ Flat ☐ Blunted ☐ Labile

**Thought Process** ☐ Normal ☐ Blocking ☐ Tangential ☐ Circumstantial ☐ Loose

**Insight:** ☐ Good ☐ Fair ☐ Poor

**Living Situation:** ☐ Alone ☐ Partner ☐ Children ☐ Siblings ☐ Parents ☐ Homeless ☐ Other

**Social Support:**

| ***Available Resources*** | ***Contact with Resources*** | | | |
|---|---|---|---|---|
| Family Members | ☐ Frequent | ☐ Occasional | ☐ Rare | ☐ Never |
| Friends/Neighbors/Coworkers | ☐ Frequent | ☐ Occasional | ☐ Rare | ☐ Never |
| Community/Religious Supports | ☐ Frequent | ☐ Occasional | ☐ Rare | ☐ Never |

**Diet:** (Food, Fluids, Habits) _____

**Substance Use:** (ETOH, Caffeine, MJ) _____ Frequency: _____

**Sleep:** (Amt, Quality, Routine) _____

**Exercise / Stress Relief:** (Type, Frequency) _____

## Assessment/Intervention:

_____

_____

_____

_____

_____

**Diagnosis:** **Axis I** **Code** _____ **Nomenclature** _____

**Code** _____ **Nomenclature** _____

**Axis II** **Code** _____ **Nomenclature** _____

## Recommendations / Referrals:

_____

_____

_____

**BH Signature:** _____ **Date:** _____ **Follow Up:** _____ **Co-Signature:** _____