UMassAmherst | Center for Counseling & Psychological Health

Psychiatric Consultation Referral Form for Community Therapists

Please complete this form and attach intake and progress notes or detailed treatment summary. Once this information is received, an initial psychiatric consultation can be scheduled.

Name of client_____ Date of referral_____

Client's Phone_____ Date of Birth_____

Referring clinician_____ Clinician phone number _____

What do you appreciate about this client? What are this client's strengths and values?

Specific reason for referral:

Please attach your initial consultation note and recent progress notes, or attach a detailed treatment summary that includes the following information:

- Presenting concern and recent course of treatment
- History of mental health symptoms and treatment
    - Significant substance use, eating or weight concerns, past psychiatric consultation, past psychiatric hospitalizations, history of suicide attempts
- Social/developmental history
- Strengths, coping skills, interests, areas of life that are going well
- Physical health and medical history
- Summary, initial formulation, and client goals

FAX or MAIL this form with attachments to:

Bee Emily, RN
Psychiatric RN Referral Coordinator
Center for Counseling and Psychological Health
University of Massachusetts Amherst
Middlesex House, 111 County Circle
Amherst, MA 01003-9255
voice: 413.545.2337
fax: 413.545.9602

Please complete this form and attach intake and progress notes or detailed treatment summary. Once this information is received, we will contact the student to schedule an initial psychiatric consultation.