Psychiatry Referral Form

Central Scheduling

PH: 937-641-3128 Fax: 937-641-6140 Toll Free Fax: 866-891-6941

One Children's Plaza • Dayton, OH 45404-1815 • childrensdayton.org

PLEASE PRINT (ALL INFORMATION IS REQUIRED)

Date of Request: ______________________________

PATIENT INFORMATION

Patient's Name: ______________________________________

☐ M ☐ F DOB: __________________________________

Parent/Guardian Name(s): ______________________________

Home Phone:____

Cell Phone:_________________Work Phone _______________

Email address:____

Preferred Contact Phone: ☐ Work ☐ Cell ☐ Home

Do you need an interpreter? ____________________________

Patient is in custody of: ☐ Parents ☐ Guardian ☐ CSB

Address: ____

City:__________________State___________Zip ____________

1st Insurance:__________________ID# ____________________

Precert # ____

2nd Insurance:__________________ID#____________________

Precert # ____

REQUESTING PROVIDER GROUP:

Office name ____

Provider name ____

Office location ____

Office contact person____________________________________

Phone ______________________Fax______________________

Signature ____

Our goal is to process referrals within two business days.
If unable to contact family within one week,
we will notify your office.

**** The psychiatry clinic can evaluate and manage medications for mental illnesses in children ages 4-17.5 years old. We do not offer formal diagnostic testing or individual therapy. ****

REASON FOR REQUEST

To be considered for an outpatient appointment, please make sure all of the questions below are answered.

Please describe the patients current symptoms/problems that may require psychiatric care.

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Has this child been diagnosed with autism or significant developmental delay? ☐ Yes ☐ No

Does this child have any chronic medical conditions? If so, please list. ☐ Yes ☐ No

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Has the child previously taken or currently taking psychotropic medications? If so, please list all medications tried. ☐ Yes ☐ No

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Has this child been psychiatrically hospitalized? ☐ Yes ☐ No

Date of hospitalization:__________________ Location of hospitalization, if not Dayton Children's: ______________________________

(PLEASE include ALL applicable clinical documentation to assist in triaging appointments.)