**Psychiatry and Medication Consultation Clinic**

**Seattle Children’s Autism Center**

**Provider Referral Form, 3 pages**

TO ENSURE APPROPRIATE SCHEDULING, PLEASE COMPLETE THIS REFERRAL FORM.

Please include relevant psychiatric records and medication trials.

**This referral will close in 30 days if not completed.**

INTERNAL/SCH REFERRALS: SEND TO AUT INTAKE REFERRAL TRIAGE

EXTERNAL/COMMUNITY REFERRALS: FAX TO 206-985-3121,

Attention: Autism Psychiatry Referral

|  |
| --- |
| **Child's First, Middle, and Last Name:** |
| Date of Birth: |
| Referring Provider: |
| Primary Care Provider: |
| Psychiatrist or Psychiatric ARNP if current: |
| Wrap-around program or residential placement if current: |

**Exclusionary Criteria: This service is not able to provide the following:**

**Acute care for suicidality, self-harm, or harm of others.**

Instead, please refer to urgent services such as

--988 Suicide and Crisis Life Line (can direct callers to specific country programs.)

--Seek emergency services.

**Long-term psychiatric care or medication management, therapy (e.g., ABA), or wrap-around care**. If you anticipate this need, please have families contact:

--Washington Statement Mental Health Referral Service for Children and Teens at 1-833-303-5437.

--Local resources, including psychiatric services within your clinic or care organization.

--Family’s insurance provider or community mental health agencies.

**Diagnosis, clarification, or confirmation of the diagnosis of autism.**

Patient must already be diagnosed with one of the following (check all that apply):

[ ]  Autism Spectrum Disorder (including past diagnosis of Asperger's and PDD NOS)

[ ]  Intellectual Disability

[ ]  Known genetic syndrome (e.g., Trisomy 21, Fragile X, Tuberous Sclerosis.)

[ ]  Known neurodevelopmental disorder (e.g., Fetal Alcohol Syndrome.)

**In order to better serve community needs, the Autism Center Psychiatry and Medication Consultation Clinic now offers two programs. Please select:**

|  |
| --- |
| **[ ]  Fast-track Psychiatric Consultation Program:** --Prioritized for timely access. --Evaluation (typically 1 to 3 appointments) and consultation with family, followed by written recommendations for care, including medications as appropriate. --Appropriate for evaluation of psychiatric concerns or behavioral problems OR specific medication-related questions.May be repeated as needed (e.g., to determine next step in care.)**[ ]  Brief Intervention Psychiatric Program:** --Evaluation followed by brief stabilization or short-term medication trial prior to return to referring provider.--Does not include therapy (e.g., ABA, Behavioral, CBT) and not a substitute for therapy or wrap-around care.--Appropriate for more complex presentations (e.g., multiple psychiatric or behavioral problems, complex comorbid medical conditions.)  |

**Please describe current question or concern:**

|  |
| --- |
|  |

**Current Psychiatric Concerns (please check all that apply):**

|  |  |
| --- | --- |
|  **[ ]** Depression, MDD **[ ]** Self-harm (non-suicidal self-injury) [ ]  Suicidal Thoughts [ ]  Suicide Attempts [ ]  Mania or Bipolar Disorder [ ]  Psychosis, Paranoia [ ]  Catatonia [ ]  Acute change in function [ ]  Anxiety (separation, school, social, etc.) [ ]  Trauma-related Anxiety or PTSD [ ]  Obsessions, Compulsions, OCD [ ]  Hair-pulling, Skin-picking |  **[ ]** Attention, Hyperactivity, Impulsivity/ADHD [ ]  Tics, Tourette's, Abnormal Movements [ ]  Oppositional Defiant or Conduct Disorder [ ]  Substance Abuse Concerns [ ]  Sleep Disorder or Concern [ ]  ARFID/Restricted or Picky Eating [ ]  Pica, Rumination, Anorexia, Bulimia [ ]  Pain Disorder/Somatic Concerns [ ]  Gender Identity or Sexuality Concerns [ ]  Other (please describe): |

**Current Behavior Problems:**

|  |
| --- |
|  [ ]  Hurts Others (e.g., hitting, scratching, pushing, kicking, biting, slapping) [ ]  Hurts Self (e.g., hits or bites self, bangs head) [ ]  Destructive Behaviors (e.g., breaking/throwing items; kicking furniture/walls) [ ]  Inappropriate Sexual Behaviors [ ]  Runs Away in the Community [ ]  Tantrums or Meltdowns (e.g., crying screaming, yelling, falling to the floor) [ ]  Noncompliance (doesn't follow directions, oppositional, argues) [ ]  Other (please describe):  |
| Has anyone, including the child, been hurt due to these behaviors (e.g., bleeding, bruising, broken bones)? [ ]  Yes [ ]  No Please describe: Where do the behaviors occur? [ ]  Home [ ]  School [ ]  Community  |

**Additional Medical Concerns:**

|  |
| --- |
|  [ ]  Seizure Disorder [ ] Other (please describe):  |

**Current Medications:**

Please provide name, dose, approximate duration, and positive and negative effects.

|  |
| --- |
|  |

**Past Medication Trials:**

Please provide name, dose, approximate duration, and positive and negative effects:

|  |
| --- |
|  |

**Current Care Team and Resources:**

|  |  |
| --- | --- |
|  [ ]  ABA (Applied Behavioral Analysis) [ ]  Other Behavioral Therapies [ ]  Speech and Language Therapy **[ ]** Other Psychological Therapy (e.g., CBT, DBT) [ ]  Occupational or Physical Therapy [ ]  Wrap-around services |  [ ]  DDA [ ]  Respite Services [ ]  School 504 [ ]  School IEP [ ]  Ben’s Fund [ ]  Other: |

**[ ] Additional information is available through Epic EMR's Epic CareEverywhere**