**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

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| **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:**

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| **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:**

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

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| 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:**

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| 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:**

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| Seizure Disorder Other (please describe): |

**Current Medications:**

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

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**Past Medication Trials:**

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

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**Current Care Team and Resources:**

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| 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**