OHSU
School of Medicine

Department of Psychiatry

Adult Psychiatry
Outpatient Clinic

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OHSU Outpatient Psychiatry Clinic

Referral Form

Thank you for choosing Adult Outpatient Psychiatry Clinic at OHSU. We offer a variety of services including: consultative services to patients and their primary care team, medication management, psychotherapy and other ongoing care treatments. In order for your patient to obtain the most benefit from his/her appointment, please provide the following documentation.

1) **Completed Referral Form**

2) **Last 3-5 pertinent chart notes**

3) **Medication History**

Please be aware that many insurance carriers and county mental health organizations limit the panel of providers authorized to treat their members. After we receive referral information, we will review clinical and insurance information and offer an intake appointment if appropriate.

Please fax the completed referral form and documentation to (503) 346-6854

If there are any questions, contact us at (503) 494-6176 to reach our intake team.

Please COMPLETE ALL sections and fax with chart notes to (503) 346-6854.
If any information is excluded we will return this form to your office for clarification.

PCP Information *(required for all consultation requests)*

Name :

Referral Coordinator / Contact Person :

Phone :

Fax :

Referring Provider *(if not PCP)*

Name :

Specialty :

Phone :

Fax :

Patient Demographics

Patient's Name :

Date of Birth :

Address :

City, State, Zip Code :

Home / Cell Phone : Work :

Insurance Information

Company : Policy Holders Name :

Policy ID # : Group # :

Insurance Phone # :

What are your patient's primary mental health challenges? *(Select all that apply)*

- ☐ Depression
- ☐ Anxiety
- ☐ Insomnia
- ☐ Substance Misuse
- ☐ Compulsive Behavior
- ☐ Suicidal Thoughts
- ☐ Mood Swings
- ☐ ADD / ADHD
- ☐ Psychotic Symptoms
- ☐ Memory Issues

Other:

What are your patients' mental healthcare needs?

- ☐ One Time Consultation
- ☐ Ongoing Medication Management
- ☐ Psychotherapy
- ☐ Neuropsychological Testing

If the patient is requesting therapy, please describe in 1-2 sentences what they hope to address.

Indicate if the patient has active substance abuse issues.

- ☐ None
- ☐ Alcohol
- ☐ Cannabis
- ☐ Illicit Substances
- ☐ Misuse of Prescription Medications

In the past 6 months, has the patient had any of the following.

- ☐ None
- ☐ Suicide Attempts
- ☐ Restricted Eating/Purging
- ☐ Emergent Psychiatric Care
- ☐ Psychiatric Hospitalizations
- ☐ Self-harm Behaviors
- ☐ Head Trauma
- ☐ Intensive Outpatient Psychiatric Care
- ☐ Substance Withdrawal

Other :

Indicate if the patient has a current or recent mental health provider(s).

- ☐ None
- ☐ Outpatient Psychiatrist / PMHNP
- ☐ Therapist
- ☐ Outpatient Neuropsychological Testing

IF Yes :

Name :

Phone # :

Fax # :

Additional Comments :