# **Referral Packet**

**Wright State University/Ohio’s Telepsychiatry Project**

**CAM (Consumer Advocacy Model)**

6 South Patterson Blvd.

Dayton, Ohio 45402

937/222-2400 -- 937/222-7522 (Fax)

Please answer all questions as completely as possible. Every word and idea is important. The questions can be answered by one or multiple people who know the individual (multiple packets for the same individual are welcome). Your time and efforts are appreciated. Please return to Nicole Duff <Nicole.duff@wright.edu>

Also please be sure to include the **current Medicaid Card and any/all available medical records** with your submission.

Name:

Date of birth:       Current age:

Home phone w/area code:       County of residence:

Home street address:

City, State and Zip:

Name of individual making referral:

Phone w/area code:       Email address:

Legal status:

Guardian:       Phone w/area code:

Email address:

 Phone w/area code:

Email address:

List all diagnoses (medical, mental health and severity of intellectual disability):

Is there a known developmental syndrome?  If Yes, please describe:

Preferred Pharmacy:

Address:

Phone w/area code:       Fax w/area code:

Please describe the symptoms of concern and referral question(s):

When did the symptoms of concern start?

What interventions have been tried and how did these work out?

When are the symptoms worse or better?

Are the symptoms worse or better in certain environments?

Does the person get, avoid, or accomplish something with these symptoms?  If Yes, please describe:

Any recent stressors/losses/changes/transitions?  If Yes, please describe:

**Medical**

List all current medications:

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| --- | --- | --- |
| **Medication** | **Dosage** | **Times per day** |
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List past medications and reaction/reason discontinued/changed/side effects:

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| --- | --- |
| **Medication** | **Reaction/Why Discontinued or Changed/Side Effects** |
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Medication allergies?

If yes, please list medications:

Hospitalization history (medical and psychiatric):

Describe the individual’s sleep pattern:

Describe the individual’s appetite and note any weight change:

Any change in bowel or bladder function or hygiene?  If Yes, please describe:

Does the individual have seizures?  If Yes, please describe:

Any changes in skin or hair?  If Yes, please describe:

Any suspicion that the person is in pain?  If Yes, please describe:

Dental problems?  If Yes, please describe:

Stomach or gastrointestinal problems?  If Yes, please describe:

Sleep apnea or excessive snoring?  If Yes, please describe:

Does the individual use alcohol, tobacco, or other substances?  If Yes, please describe:

Family medical and psychiatric history:

Any history of trauma/abuse:  If Yes, please describe:

Any involvement in the legal system:  If Yes, please describe:

**Psychiatric**

Any suspicion of hallucinations? (seeing, hearing, smelling, tasting, or being touched)  If Yes, please describe:

Any suspicions of delusions/paranoia? (fixed, false beliefs)  If Yes, please describe:

Are there any rituals or compulsive acts?  If Yes, please describe:

Any unusual physical movements? (rocking, tics, gait, etc.)  If Yes, please describe:

Anxiety or panic attacks?  If Yes, please describe:

How is the person’s memory?

How does the person respond to stress?

Any changes in cognitive function/thinking process?  If Yes, please describe:

What is the person’s general mood?

Has there been any suicidality or homicidality?  If Yes, please describe:

When was this individual last doing well?

Provide every detail you can recall from that time period (How long ago? Include medication list, living situation, support system, occupational/educational setting)

Add any piece of information you feel is important which has not been described in the previous questions:

**Please attach any medical records &/or any other documentation** which may be helpful to fully understand this individual. Again, thank you for your time and effort. It is very much appreciated.