REFERRAL PACKET

Ohio's Telepsychiatry Project
Access Ohio Mental Health Center of Excellence
2611 Wayne Avenue, Building #61
Dayton, Ohio 45420
Phone 937/641-8554 Fax 877/938-3265

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 referral packet to Nev Moore at nev.moore@accessoh.net

Please also include the **current Medicaid Card and any/all available medical records** with your submission.

Name:_____
Date of birth:_____ Current age:_____
Street address_____
CityStateZip_____
County of residence:_____
Home phone w/area code:_____

Preferred Pharmacy:_____
Street address:_____
CityStateZip_____
Phone number w/area code:_____ Fax number:_____

Name of person making referral:_____
Email address:_____
Phone number w/area code:_____

Legal Status:_____

Name of guardian:_____
Email address:_____
Phone number w/area code:_____

Name of Case Manager/Services & Support Administrator_____
Email address:_____
Phone number w/area code:_____

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

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

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? Yes_____ No_____
If Yes, please describe:_____

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

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

MEDICAL

List all current medications with dosages/scheduling:

MEDICATION	DOSAGE	TIMES PER DAY

List past medications and reaction/reason discontinued/changed/side effects:

MEDICATION	REACTION/REASON DISCONTINUED/CHANGED/SIDE EFFECTS

Medication allergies? Yes_____ None known:_____
If Yes, 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? Yes_____ No_____
If Yes, please describe:_____
_____
_____
_____

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

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

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

Dental problems? Yes_____ No_____
If Yes, please describe:_____
_____
_____

Stomach or gastrointestinal problems? Yes_____ No_____
If Yes, please describe:_____
_____
_____
_____

Sleep Apnea? Yes_____ No_____ Excessive snoring? Yes_____ No_____

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

Family medical and psychiatric history:_____

Any history of trauma/abuse? Yes_____ No_____
If yes, please describe:_____

Any involvement in the legal system? Yes_____ No_____
If yes, please describe:_____

PSYCHIATRIC

Any suspicion of hallucinations? (seeing, hearing, smelling, tasting, or being touched) Yes___ No___
If yes, please describe:_____

Any suspicions of delusions/paranoia? (fixed, false beliefs) Yes_____ No_____
If yes, please describe:_____

Are there any rituals or compulsive acts? Yes_____ No_____
If yes, please describe:_____

Any unusual physical movements? (rocking, tics, gait, etc.) Yes_____ No_____
If yes, please describe:_____
_____
_____
_____

Anxiety attacks? Yes_____ No_____ Panic attacks? Yes_____ No_____

How is the person's memory?_____
_____
_____

How does the person respond to stress?_____
_____
_____

Any changes in cognitive function/thinking process? Yes_____ No_____
If yes, please describe:_____
_____
_____
_____

Describe the person's general mood?_____
_____
_____
_____

Has there been any suicidality or homicidality? Yes_____ No_____
If yes, please describe:_____
_____
_____
_____

When was this individual last doing well? Give every detail you can recall from that time period (how long ago? medication list, living situation, support system, occupational or educational setting)
_____
_____
_____
_____
_____
_____

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

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