SWVTC RCSC REFERRAL FOR PSYCHIATRIC CONSULTATION

Client: ____________________________

Reason for Referral:____
____

Precipitating Events:____

Current Medication: Name Dosage Prescribed by:
____
____
____
____

Previous Medication Trials: Name Helpful?
_________________________ Yes/No
_________________________ Yes/No
_________________________ Yes/No
_________________________ Yes/No

Current Psychiatrist or M.D. prescribing psychotropics:_____________________________
Address:_____________________________
____
Phone:_____________________________

Other Mental Health Care Providers:_____________________________________
Address:_____________________________________
____
Phone:_____________________________________

Previous Psychiatric Treatment Where When

Inpatient:
____
____
____

Outpatient:
____
____
____

(Please attach copies of any available reports on prior consultations or treatments)

Completed By:____________________________________ Date:______________

When completed Fax to SWVTC at (276) 728-3127; Attention: RCSC Referral