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Geriatric Psychiatric Clinical Service
Form to be filled out by Referring Mental Health Provider or Primary Care Provider

Date:_____Time:_____(referral valid for 30 days)

Patient:_____Date of Birth: _____

Private Phone #: _____

Referring Provider*:* MD/DO/NP: _____

Phone:_____Fax:_____Email: _____

Are translation services required? Yes ☐ No ☐

- Please include a copy of your **last progress note** that includes a complete mental status exam, safety assessment, and current treatment plan.
- Please include a copy of patient's updated **demographics** form and/or insurance card.

Identifying Data:

_____

_____

Reason for Referral:_____

Current and Past Psychiatric Diagnoses (choose appropriate specifiers):

- ☐ MDD: single episode / recurrent, moderate / severe, with / without psychotic features
- ☐ Bipolar I / II: current episode depressed / manic / mixed, with / without psychotic features
- ☐ Schizophrenia: _____
- ☐ Schizoaffective Disorder: _____
- ☐ Active Substance Use Disorders: _____

  _____
- ☐ History of Substance Use Disorders: _____

  _____

☐ PTSD ☐ GAD ☐ OCD

☐ Dementia ☐ Mild Cognitive Impairment ☐ Other Neuropsychiatric Symptoms

_____

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Please Describe Concerns about Cognitive and Psychological Functioning:

Psychiatric History

Hospitalizations

Suicide Attempts

Active Medical Problems

Current Psychiatric Medications □ None	**Current Dose**	**Prescribed for > 3months**
		□ Yes □ No
		□ Yes □ No
		□ Yes □ No

Other Relevant Information:

The Geriatric Psychiatry providers will serve as consultants in the care of your patient.

Print Referring Health Care Provider's Name	*Health Care Provider's signature*	*Date*	*Time*

Return by **EMAIL** to **BUMCSPsychReferral@BannerHealth.com**
Attention: Geriatric Psychiatry Clinical
Questions: 520-874-7500.