

Psychiatric Referral Form

Smith DiSalvo Vajen

Client Name: _____ ID: _____ Date: _____

List the presenting diagnosis that is likely to benefit from medication:

What current symptoms are likely to improve through medication?

How have these symptoms been addressed without medication?

Any potential contraindications to medication (ie. drug seeking, history of allergic reaction, etc.):

What supporting documentation (collateral materials/clinical observation data/assessment data) do you have indicating that the client experiences the above symptoms?

- Financial Implications discussed with client/guardian. If not, why not?
- Reason(s) explained to the client/guardian for the referral. If not, why not?
- Client/guardian participated in the referral. If not, why not?

What was the client/guardian's response to the change?

Referring Clinician

Clinical Supervisor

Approved Not Approved—Why:

Team Leader

Controlled Substances Treatment Agreement

The purpose of the Agreement is to prevent misunderstandings about certain medicines you will be taking for the treatment of mental health and/or emotional conditions. This is to help both you and your mental health providers (including your prescribing doctor, therapist, and/or case manager) comply with the law regarding controlled medications.

I understand that if I break this Agreement, my doctor will stop prescribing medications. If I break this agreement, my doctor may taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. A substance abuse treatment program may also be recommended if there are indications of substance abuse or dependence.

I understand that I have the following responsibilities:

I will take medications at the dose and frequency prescribed.

I will not store unused medications.

I will obtain all refills for these medications only at _____ pharmacy. Phone #: _____. If I decide to change pharmacies, I will notify Mid-Ohio Psychological Services.

I will protect my prescriptions and medications. Lost, misplaced, or stolen medication will not be replaced. If my medications are repeatedly lost or stolen, the medication will be tapered and discontinued.

I will keep medications only for my use and will not share them with others or sell them. The medication should never be given or sold to others.

I will keep all medications away from children.

In order to safely prescribe and monitor controlled medications, Mid-Ohio Psychological Services may request one or more of the following:

I may be asked to submit to drug screening to assure that medication is being taken as indicated. Drug screening measures may also be utilized to identify and monitor other potential substance abuse issues.

I will be asked to appropriately dispose of any unused medications. This may be done by surrendering the medication to my doctor, therapist, or case manager; or by my doctor adjusting quantities of future prescriptions.

My doctor or other mental health provider may ask to complete a "pill count" to monitor compliance with medication.

Mid-Ohio Psychological Services will actively monitor medication compliance and response to medication. Failure to attend appointments as scheduled with my doctor, therapist, and/or case manager may result in a discontinuation of medication.

Mid-Ohio Psychological Services may recommend additional treatment (therapy/counseling, case management, etc) to assist me in treating my mental health or emotional needs.

Mid-Ohio Psychological Services may discontinue these medications if the medications do not achieve the desired treatment outcome (reduction in emotional symptoms, improvement in functioning), or if I develop significant side effects from the medication.

Client: Print Name and Sign

Date

Therapist/Case Manager: Print Name and Sign

Date

Clinical Supervisor: Print Name and Sign

Date

Reviewed by Physician: Print Name and Sign

Date