THE University of Vermont MEDICAL CENTER

UVM Medical Center Child Psychiatry
1 South Prospect Street, Arnold Level 3
Burlington, VT 05401
FAX: (802) 847-7998 PHONE: (802) 847-4563

Child and Adolescent Psychiatry Clinic Request

Please complete this form in its entirety and fax it to the number above in order to start the referral process. This form along with other paperwork is required to be completed prior to scheduling an appointment. Be advised we only see patients that are 18 or under and still in grade school.

Pt Name: _____ DOB: _____ Relevant Identities: _____
Patient's Address: _____City: _____ State: _____ Zip: _____
Phone Number: _____ Email: _____

Parents/Guardians/Custody for medical decisions/DCF/CPS custody list caseworker or primary contact:

Name/Relationship to patient: _____ Phone #: _____

Name/Relationship to patient: _____ Phone #:_____

Please Ask Family: Race/Ethnicity: _____
Interpreter Preferred? ☐ Yes ☐ No Preferred language? _____

Would you benefit from help completing paperwork to the Psychiatry Clinic? ☐ Yes ☐ No

Insurance Type: _____[Please note: United Behavioral Health(UBH)/Optum insurance coverage for mental health services is required to be paid out of pocket, as our services are currently considered Out-Of-Network.]

Referring Physician: _____ Primary Care Clinician (if different): _____

Primary Care Physician (if different from above): _____

Name of Practice: _____ City: _____

Email: _____ Phone Number:_____

Have you called VT Child Psychiatric Access Program (VTCPAP) for this patient (802-488-5342)? ☐ Yes ☐ No

Would you like a telephone consultation call from VTCPAP regarding this patient? ☐ Yes ☐ No

REASON FOR CONSULTATION:

☐ Diagnostic Clarity ☐ Medication Management ☐ Parenting Coaching ☐ Therapy ☐ Second Opinion
☐ Other _____
Brief Description: _____

* Please attach most recent notes, labs, studies, and/or clinical summary of medical and psychiatric history. We are working to improve access to psychiatric evaluation and management. Patients who do not need ongoing psychiatric specialty level care will be transferred back to primary care for ongoing management. Please sign to confirm you will continue ongoing management for this patient.

SIGN HERE: _____ Date/Time: _____

OFFICE USE ONLY:

Patient seen before: ☐ NO ☐ YES Clinician _____Date _____