



CHKD Mental Health Service Line
601 Children's Lane
Norfolk, VA 23507
757.668. HOPE
757.668.5686 FAX

CHKD Outpatient Mental Health Referral Form

Our team is committed to offering accessible care options for all children. If a referral is determined to be outside the scope of CHKD Outpatient Mental Health services, we will provide the guardian with appropriate external resources to ensure the child receives the necessary treatment and support. Waitlist placement or resources may take 5 to 10 business days to process. If a patient is experiencing an urgent or acute mental health issue and needs to be assessed right away, advise them to seek evaluation at the nearest emergency room, the CHKD Emergency Department, or to call 911.

Please fax this completed form and **at least three recent office visit notes** to (757) 668-5686 or email it to MHReferralServLine@CHKD.ORG. The referral will not be processed until the team has received these documents.

Are you a VMAP enrolled physician? Yes [] No []

Referral Data

Referring Physician: _____ Date: _____
Practice Name: _____ Phone: _____
Office Contact: _____ Fax: _____

Patient Information

Patient Name: _____ Address: _____
Gender: _____ DOB: _____
Caregiver Name: _____ Caregiver Phone: _____
Language(s) spoken at home: _____ Interpreter required: Yes No
Primary Insurance: _____ or copy of insurance card.

Please respond to the following questions (check all that apply):

- What concerns prompted this referral?

<input type="checkbox"/> Mood/Depressive symptoms	<input type="checkbox"/> Eating/Feeding issues
<input type="checkbox"/> Conduct (Parent Childre Interaction Therapy)	<input type="checkbox"/> Chronic Medical Illness
<input type="checkbox"/> Aggressive Behavior	<input type="checkbox"/> Trauma
<input type="checkbox"/> Anxiety (OCD, panic, phobias)	<input type="checkbox"/> Autism Spectrum Disorder (please indicate level of ASD __)
<input type="checkbox"/> Attention Deficit Hyperactivity Disorder	<input type="checkbox"/> Other: _____
- What services are you requesting?
 - Medication Management
 - Psychological Testing
 - Mental Health Therapy
 - Bridge Crisis Clinic (BCC)
 - Health Psychology
 - Intensive Outpatient Program (Virginia Beach location only)
 - Foster Care Evaluation

<input type="checkbox"/> Inpatient	Past	Current	Both	<input type="checkbox"/> Medication management by PCP	Past	Current	Both
<input type="checkbox"/> Residential	Past	Current	Both	<input type="checkbox"/> Outpatient therapy	Past	Current	Both
<input type="checkbox"/> 504 Plan/IEP	Past	Current	Both	<input type="checkbox"/> In-home services	Past	Current	Both
<input type="checkbox"/> Psychiatry	Past	Current	Both	<input type="checkbox"/> Psychological Testing	Past	Current	Both
<input type="checkbox"/> IOP	Past	Current	Both	<input type="checkbox"/> PHP	Past	Current	Both

1. Based on your assessment, can this patient's symptoms and behaviors be managed with routine outpatient therapy and/or medication treatment?

- Yes
- No

2. To your knowledge, in the last 30 days, has the patient experienced an increase in mental health symptoms?

- Yes
- No

3. To your knowledge, in the last 30 days, has the patient been unable to maintain functioning in the home, school, or community setting?

- Yes
- No

4. Has the patient recently been discharged from inpatient care?

- Yes
- No

a. If yes, approximate date of discharge?

Additional Comments and Referral Information: