



**Mental Health Service Line
Outpatient Services Referral Information:**

We are working hard to build a Mental Health Service Line with care access opportunities for all children in need. We currently have a high volume of requests and partner with mental health agencies outside of CHKD to ensure all children referred receive appropriate treatment resources. Please give our team 5-10 business days to review referrals and connect families to resources.

If your patient has an **urgent/acute** mental health concern and they require immediate assessment, recommend mental health evaluation at the closest emergency room or the CHKD Emergency Department or call 911.

**Please fax this completed form and at least 3 last office visit notes to 757-668-8870 or
MentalHealthReferral@CHKD.ORG** (the referral will not be process until the team receives these)

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: _____ **Age:** _____
Caregiver Name: _____ **Caregiver Phone #:** _____
Language spoken at home: _____ **Interpreter required: Yes No**
Insurance Information (please include copy of insurance card):
Primary Insurance: _____ **Subscriber Name:** _____ **DOB:** _____
Policy #: _____ **Group #:** _____

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

1. What concerns prompted this referral?

<input type="checkbox"/> Mood/Depressive symptoms	<input type="checkbox"/> Eating/Feeding issues
<input type="checkbox"/> Disruptive/Aggressive Behavior	<input type="checkbox"/> Chronic Medical Illness
<input type="checkbox"/> Anxiety (OCD, panic, phobias)	<input type="checkbox"/> Autism (please indicate level of ASD __)
<input type="checkbox"/> Trauma	<input type="checkbox"/> Other: _____

2. What services are you requesting?
 - Medication Management
 - Psychological Testing
 - Mental Health Therapy
 - Bridge (BCC)
 - Intensive Outpatient Program (Virginia Beach location only)

3. What are the past or current treatments?

<input type="checkbox"/> Inpatient	<input type="checkbox"/> Outpatient therapy
<input type="checkbox"/> Residential	<input type="checkbox"/> In-home services
<input type="checkbox"/> 504 Plan/IEP	<input type="checkbox"/> Psychological Testing
<input type="checkbox"/> Medications	<input type="checkbox"/> Developmental Pediatrics
<input type="checkbox"/> CAC	<input type="checkbox"/> Psychopharmacological management by Primary Care

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?

5. Is the patient being referred for foster care evaluation?

- Yes
- No

6. Is the patient being referred for psychological testing?

- Yes
- No

Additional Comments and Referral Information:

OON Referrals