Children's Hospital of The King's Daughters Health System

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

CHILDREN'S SPECIALTY GROUP

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 an appropriate treatment resource. Please give our team 5-10 business days to review referrals and connect families to resources. Families referred to our programs will be notified of recommended services via phone or mail. As the referral treatment provider, you will also receive correspondence on the outcome of the referral.
- A letter will be mailed to the family and referring provider to indicate if the family is on a waitlist or if community resources were provided to the family to best support.
- If you, your families, or your staff have any questions or concerns please contact our main office number at **757-688-HOPE.**
- 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 along with at least 3 last office visit notes to **757-668-5686.**

Referral Data

Referring Physician: _____ **Date:** _____

Practice Name: _____ **Phone:** _____

Office Contact: _____ **Fax:** _____

Patient Information

Patient Name: _____ **City/State of Residence:** _____

Gender: _____ **Age:** _____ **Caregiver Name:** _____

Insurance Provider: _____ **Caregiver Phone #:**_____

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

1. What concerns prompted this referral?
   - [ ] Mood
   - [ ] Disruptive Behavior
   - [ ] Anxiety (OCD, fears, panic, phobias)
   - [ ] Learning and Development (intellectual disabilities, Autism, school problems)
   - [ ] Trauma
   - [ ] Eating/Feeding
   - [ ] Chronic Medical Illness
   - [ ] Foster Care Evaluation
   - [ ] Other: _____

2. What services are you requesting?
   - [ ] Psychiatric Evaluation and Med Management (Psychiatrist/Psychiatric Nurse Practitioner)
   - [ ] Psychological Evaluation and Testing (Psychologist)
   - [ ] Mental Health Therapy (Mental Health Therapist)
   - [ ] 2nd Opinion: _____
   - [ ] Unknown

3. What are the past or current treatments?
   - [ ] Inpatient
   - [ ] Residential
   - [ ] 504 Plan/IEP
   - [ ] Medications
   - [ ] Child Abuse Program
   - [ ] Outpatient therapy
   - [ ] In-home services
   - [ ] Psychological Testing
   - [ ] Developmental Pediatrics
   - [ ] Psychopharmacological management by Primary Care

OON Referrals