C.A.P.E.S. Program for Primary Care Physicians

"Together We Can Help More Children"

Child and Adolescent Psychiatric Telephone Consultation Request

Please Fax to 518-583-9301

Physician Name: _____ Date: _____

Medical Group: _____ City_____

Phone:_____ Fax:_____

Patient Information:

__Male __ Female DOB/age: _____ City:_____

Working diagnosis: _____ diagnosis unclear

Allergies: _____ Current Therapist: _____

Does the Patient Have Insurance: Yes or No If yes, what insurance:_____

Consultation Question: _____

_____

_____

Current Medication(s):

_____
_____
_____
_____

Previous Medication Trials:

_____
_____
_____
_____

Significant/ Relevant History: (That can be discussed during the telephone consultation)

- Psychiatric History:
- Developmental History:
- Medical History:
- Family Medical/ Psychiatric History:
- Social History:

Psychiatrist Recommendations: _____

_____

_____

Working Diagnosis:_____Include list of Outpatient Referral Sources:____Yes_____ No

_____ _____

Consultant's Signature Date

Case Number:_____ Referral Info. Attached: Y or N

30 Crescent Avenue, Saratoga Springs, NY 12866 · 1-800-888-5448 · 518-584-3600 · fax: 518-583-9301