Children's Mental Health Resource Center
Physician Referral Request

Fax completed form to (866) 594-3117.

Call (804) 828-9897 for assistance.

Date: ______________________________

REFERRING PHYSICIAN INFORMATION

Name:______________________________ Group/Practice: ______________________________

Phone #:______________________________ Fax #: ______________________________

CHILD'S INFORMATION

Name:______________________________ DOB: ______________________________

☐ Ethnicity & race (choose one or more): ☐ Black ☐ Hispanic or Latino ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other Asian

Speaks Spanish **and** requires an interpreter? ☐ Yes ☐ No

Guardian's name:______________________________ Guardian's relationship: ______________________________

Home phone:______________________________ Cell phone: ______________________________

Address (include zip code): ______________________________

REASON FOR REFERRAL

Mood issues:
- ☐ Anxiety
- ☐ Depression
- ☐ Mood swings
- ☐ Suicidal ideation

Behavior issues:
- ☐ Aggression
- ☐ Destructive behavior
- ☐ Hyperactivity
- ☐ Poor focus/forgetful

Other:
- ☐ Eating/appetite problems
- ☐ Family discord
- ☐ Psychosis
- ☐ Sleep problems
- ☐ Trauma/PTSD

Other (please describe): ______________________________

TYPE OF SERVICE REQUESTED

- ☐ Evaluation (circle all that apply below)
- ☐ autism, ADHD, developmental, psychological, other: ______________
- ☐ Intensive in-home services
- ☐ Outpatient counseling
- ☐ PCP requests phone consultation with a psychiatrist
- ☐ Peer support/support group
- ☐ Psychiatric/medication evaluation

Other (please describe): ______________________________

INSURANCE INFORMATION FOR CHILD

Name of insurance provider:______________________________ At this time, we do not require an insurance number.

Is this Medicaid? ___Yes ___No

☐ No insurance at this time

CHILDREN'S HOSPITAL OF RICHMOND AT VCU

VCUHealth™

mentalhealth4kids.org