**Referral Form**

A completed referral form is required before a patient’s first visit.

If you have any questions regarding our clinic, please call **713-486-2621**.

Please fax the completed form to **713-500-2728**, attention to **Kimberly M. Boyette, LVN**.

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| Patient Name |  | | | |
| Phone Number |  | | Date of Birth |  |
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| The patient is currently in need of psychiatric hospitalization and is not stable. Please refer the patient to the **Treatment-Resistant Depression Unit** at the **UTHealth Dunn Behavioral Sciences Center** for admission. Admissions can be contacted directly at 713-500-1500. | | | | |
| The patient is not in need of direct psychiatric hospitalization. Please continue to fill out this form. | | | | |
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| Reason for referral:  Treatment-resistant depression  Catatonia  Treatment-resistant mania  Treatment-resistant schizophrenia  Treatment-resistant obsessive-compulsive disorder  Unspecific treatment-resistant behaviors/symptoms such as\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
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| Diagnosis |  | | | |
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| Estimate the length of the current episode |  | | | |
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| Brief Psychiatric History |  | | | |
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| Suicidal History |  | | | |
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| Chemical Dependency History |  | | | |
| Pharmacogenomics Testing History | Yes - Please attach a copy  No | | | |
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| Current Medication | | | | |
| Name of Medication | Dose | Duration of Trial | Outcome (effective/ineffective/discontinued due to side effects) | |
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| Past Medication Trials | | | | |
| Name of Medication | Dose | Duration of Trial | Outcome (effective/ineffective/ discontinued due to side effects) | |
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| Current Psychotherapy | | | | |
| Name of Therapist | Therapeutic Approach | Duration of Trial | Outcome (effective/ineffective/discontinued due to any reason) | |
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| Past Psychotherapy Trials | | | | |
| Name of Therapist | Therapeutic Approach | Duration of Trial | Outcome (effective/ineffective/discontinued due any reason) | |
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| Past TMS Trials | | | | |
| Name of Provider | Protocol  (37 min/19 min/3 min) | Number of Sessions | Outcome (effective/ineffective/ discontinued due side effects) | |
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| Past Ketamine or Esketamine (SpravatoTM) Trials | | | | |
| Name of Provider | Dose | Number of Administrations | Outcome (effective/ineffective/ discontinued due to side effects) | |
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| Past ECT Trials | | | | |
| Name of Provider | Protocol  (unilateral/bilateral) | Number of Sessions | Outcome (effective/ineffective/ discontinued due side effects) | |
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| Additional Comments |  | | | |
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| Indicate how frequently you would like to be informed of your patient’s progress |  | | | |
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| How would you like to be contacted? | Phone  Fax  E-mail | | | |
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| Referring Provider Printed Name |  | | | |
|  |  | |  | |
| Phone |  | | | |
| Fax |  | | | |
| E-mail |  | | | |

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| Referring Provider Signature  *(required for insurance purposes)* |  |
| Date |  |