**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. |
|  |  |
| 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 |  |
|  |  |
| How would you like to be contacted? | [ ] Phone[ ] Fax[ ] E-mail |
|  |  |  |
| Referring Provider Printed Name |  |
|  |  |  |
| Phone |  |
| Fax |  |
| E-mail |  |

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