**PSYCHIATRY APPOINTMENT CONSULT FORM**

|  |  |
| --- | --- |
| **Person’s Name:**  | **Appointment Date:**  |
| **Date of Birth:** | **Age:** |
| **Residential Provider:** | **Residential Provider Contact:** |
| **Day Services Provider:** | **Day Services Contact:** |
| **Physician’s Name:** | **Date of last quarterly Psychotropic Medication Review:** |

|  |
| --- |
| **(This section to be completed by prescriber)** |

**DSM DIAGNOSIS:**

**IMPRESSIONS and RECOMMENDATIONS:**

[ ]  **I find NO CHANGES ARE NEEDED. Continue current orders and recommendations.**

[ ]  **I find CHANGES ARE NECESSARY. Revised orders and recommendations are listed below.**

**ORDERED PSYCHOTROPIC MEDICATIONS:**

**Please list** [Medication; Dosage/Route/Frequency; Symptom targeted by medication; Psychiatric diagnosis targeted by medication]

**LABS ORDERED TODAY (IF ANY)** Metabolic screening/Labs/Diagnostic tests ordered:

**FOLLOW UP APPOINTMENT DATE/ TIME:**

|  |  |
| --- | --- |
| **Physician’s Printed Name and Signature** | **Date** |
| **Physician:** |  |

Form revised October 10, 2019