UPMC LIFE CHANGING MEDICINE
Western Psychiatric Institute and Clinic
3811 O'Hara Street
Pittsburgh, PA 15213 –2593

Conroy- Merck Referral Form

Date of referral: _____

Eval Needed: ***YES*** ***NO***

DEMOGRAPHIC INFORMATION:

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Patient Information

Name_____WPIC#_____

Sex: M / F Race: C/AA/Asian/other_____ Birth date: _____ Age: _____

Address_____
Street City State Zip Code

Area/Neighborhood: _____

Telephone: (____)_____ (____)_____ SS#_____-____-____
Home Work

School: _____ Grade: _____ MR Spec. Ed. ES LS AS

Parent or Guardian Information

Name_____ Relationship_____

Parent aware of referral? Yes / No CYF Involvement? Yes / No

Referral Information

Name_____ Title/Position_____

School District_____ Telephone #_____

Address_____
Street City State Zip Code

Insurance Information

Private: Yes / No Insurance Name: _____

Pre-certification Agency:_____ Phone_____

Named of Insured:_____ SS#_____ Relationship_____

Employer_____ Policy#_____ Group#_____

Medical Assistance: Yes / No Insurance Name: _____

MA # _____

CLINICAL INFORMATION:

Most Immediate Problem/Chief Complaint: _____

Review of Systems/Risk Assessment (indicate current or history of):

Aggression: ❑ Not Present ❑ Verbal ❑ Physical/Fighting ❑ Use of weapons ❑ Family Hx
❑ Police involvement due to aggression ❑ Property Destruction
Explain/Other:_____

Environmental Risks: ❑ Not Present ❑ Unsafe Surroundings ❑ Unstable Situation ❑ Weapons Present
Explain/Other:_____

Impulsivity: ❑ Not Present ❑ Bolting ❑ Climbing ❑ Hiding
Explain/Other:_____

Substance Use/Abuse: ❑ Not Present ❑ ETOH ❑ THC ❑ Other
Explain/Other: _____

Suicidality: ❑ Not Present ❑ PDW ❑ Ideation ❑ Plan ❑ Gesture ❑ Attempt
Explain/Other: _____

SIB: ❑Not Present ❑ Yes ❑ Hx
Explain/Other:_____

Homicidality: ❑ Not Present ❑ Ideation ❑ Plan ❑ Gesture ❑ Attempt
Explain/Other: _____

Psychosis: ❑ Not Present ❑ AH ❑ VH ❑ Delusions ❑ Paranoid Ideation
Explain/Other: _____

Abuse hx: ❑ Not Present ❑ Physical ❑ Emotional ❑ Sexual Reported? Yes / No
Explain/Other: _____

Mood: ❑ Not Present ❑ Depressed ❑ Irritable ❑ Euphoric ❑ Anhedonia ❑ Labile ❑ Neurovegetative
Explain/Other:_____

Anxiety: ❑Not Present ❑School ❑Separation ❑Social ❑Obsessive-Compulsive
Explain/Other: _____

Relationship Problems: ❑ Not Present ❑ Family ❑ Adults ❑ Peers
Explain/Other:_____

ADHD: ❑ Not Present ❑ Inattentive ❑ Hyperactive ❑ Fidgety ❑ Impulsive ❑ Distractible
Explain/Other: _____

Oppositionality: ❑ Not Present ❑ Home ❑ School
Explain/Other:_____

Conduct: ❑ Not Present ❑ Stealing ❑ Fire Setting ❑ Animal Cruelty ❑ School Truancy ❑ Runaway
❑ Legal Issues
Explain/Other: _____

Reason for Referral:

___ step-down from in-patient
___ multiple hospitalizations/stabilization
___ lack of improvement in current program
___ hospital diversion
___ crisis stabilization
___ other_____

Diagnosis(es):

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

Please list **ALL** medications, vitamins, supplements or over the counter (OTC) drugs that your child is taking. If it is prescribed by a doctor, please include the MD name and a phone number.

Name	**Dose**	**Time (s)**	**MD Name**	**MD Phone #**

Pharmacy Name and Number:_____

PCP Information:

Name: _____

Address: _____

Phone Number: _____

Please list ALL other Providers involved in your Child's care: (ie: Neurologist, Endocrinologist, Wraparound/BSC/TSS.MT, Family Based…)

Type of Service:	**Contact Person**:	**Phone**:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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