Pediatric Psychiatry Collaborative (PPC)

Atlantic Health Hub at Newton Medical Center Consult Form

This form must be completed in its entirety by an office staff member or physician. A PPC-approved primary screening tool must accompany this form. Any missing information will delay our ability to process the consult. (Patient/caregiver is not to complete this form).

Fax to (973) 383-3506

Date of Referral/Contact	______/______/______	***For Hub use only*** Patient ID: ____________ MR #: ____________
County	☐ HUNTERDON ☐ SOMERSET ☐ SUSSEX ☐ WARREN	
Referring Practice	Practice Name: ____________ Referring Physician (Attending): ____________ Resident Name, if applicable: ____________ Office Phone: ____________ Cell Phone: ____________	
Patient Information	Last Name: ____________ First Name: ____________ DOB:______/______/______ Age:____ Gender: ☐ MALE ☐ FEMALE Dept. of Children and Families (DCF) Involvement: ☐ YES ☐ NO ☐ PREVIOUSLY (CLOSED) Grade Level: ____________ Accommodations: ☐ None ☐ IEP ☐ 504 Plan ☐ Other: ____________	
Parent/Caregiver Information ***(Patient information must be provided if patient is 18 or older)***	Last Name: ____________ First Name: ____________ Phone 1: ____________ Phone 2: ____________ Email: ____________ Street Address: ____________ City/State/Zip: ____________ Relationship to Patient: ☐ Mother ☐ Stepmother ☐ Adoptive Parent ☐ Grandparent ☐ Self ☐ Father ☐ Stepfather ☐ Foster Parent ☐ OTHER (describe):	
Primary Language	☐ English ☐ Non-Verbal ☐ American Sign Language ☐ Russian ☐ French ☐ Spanish ☐ French-Creole ☐ Other: ____________	
Hispanic Origin	☐ NO (Not of Hispanic, Latino, or Spanish origin) ☐ YES ☐ Cuban ☐ Puerto Rican ☐ Mexican, Mexican-American, or Chicano ☐ South or Central American ☐ Other Hispanic/ Latino: ____________	
Race	☐ American Indian or Alaskan Native ☐ White ☐ Asian ☐ Other: ____________ ☐ Black or African American ☐ Declined to Answer ☐ Native Hawaiian or Other Pacific Islander	

Patient Name:__________________________

Type of Insurance	**Medicaid:** ☐Aetna Better Health ☐Amerigroup ☐Horizon NJ Health ☐UnitedHealthcare Community Plan ☐WellCare **Private:** ☐Aetna ☐Cigna ☐Horizon Blue Cross Blue Shield ☐QualCare ☐United Health Care Other: __________
Screening Tool and Score/Result ***(Please attach completed screen(s) when submitting this form)***	**Primary Screening Tools REQUIRED, based on ages listed:** SWYC (Caregiver for Up to Age 5) → Milestones: ______ BPSC/PPSC (circle): ______ PSC-35 (Caregiver for Ages 6 and Up): ______ PSC-Y-37 (Ages 11 and Up): ______ PSC-Y (Ages 11 and Up): ______ CRAFFT (Ages 12 and Up): ______ **Please send any additional screening tools that you may feel are appropriate.**
Reason for Hub Referral/Contact ***(check all that apply)***	☐Behavioral Health TX Consult ☐Follow-up ☐Parent Guidance ☐Community Referral ☐Medication Consult ☐School Guidance ☐Diagnostic Clarification ☐Other: __________
Symptoms/ Problems Leading to Referral/Contact	**Problems:** ☐Aggression ☐Disruptive Behavior ☐Emotional Abuse ☐Legal Problems ☐Physical Abuse ☐School Issues ☐School Refusal ☐Sexual Abuse ☐Sleep Problems ☐Social Issues ☐Substance Abuse **Symptoms:** ☐Anxiety ☐Attention Issues ☐Changes in Appetite/Weight ☐Changes in Sleep ☐Depression ☐Enuresis/Encopresis ☐Hyperactivity ☐Mood Changes ☐Phobias ☐Psychotic/Delusional Thinking ☐Vocal/Motor Tics **High Risk Factors:** ***(Within Past 6 Months)*** ☐Homicidal Ideation ☐Inpatient Hospitalization ☐Overdose ☐Self-injurious behavior ☐Suicidal Ideation ☐Other: __________
Existing Diagnosis at Time of Consult	☐No Psychiatric Diagnoses ☐ADHD ☐Adjustment Disorder ☐Anxiety Disorder ☐Autism Spectrum Disorder ☐Bipolar Disorder ☐Depressive Disorder ☐Eating Disorder ☐Impulse Control, ODD, Conduct Disorder ☐Intellectual, Social, Learning Disability ☐Mood Disorder NOS ☐OCD ☐Personality Disorder/Trait ☐Psychotic Disorder ☐PTSD/Trauma ☐Substance Use Disorder (please identify substance): __________ ☐Other: __________
Medication History	**List current psychiatric medications:** __________ __________ __________ ☐None **List psychiatric medications in patient past history:** __________ __________ __________
Patient/ Parent/Caregiver Concern	Did either the child or parent, or both parties, express concern about child's emotional or behavioral well-being? ☐YES ☐NO
Current Counseling Status	Is the patient currently receiving counseling services? ☐YES ☐NO

Form Completed By:__________________________

Any questions, call (973) 579-8574. Thank you!

Please note that the PPC Hub is not a crisis center. If your patient is in crisis (at immediate risk of harming themselves or someone else), please send them to the nearest emergency room, call 911, or call Mobile Response at 1-877-652-7624. Any reports of child abuse/neglect must be reported to DCP&P at 1-877-652-2873.

Primary Care Partners
Affiliated with
Atlantic Health System

Authorization for RELEASE of Information

This form is to be used for releasing information to other physicians, facilities, schools, and outside agencies. In addition, this form is to be used when a patient wants their records to be transferred.

I do hereby consent to and authorize Primary Care Partners **SKYLANDS PEDIATRICS PRIMARY CARE PARTNERS AFFILIATE** (Name of Care Center) to disclose to the facility/person(s) named, information from my medical records relating to my treatment. This release is to be **limited** to the specified reports within the **specified dates of treatment** I have indicated below. I understand that this consent shall operate as a complete release of liability to Primary Care Partners, the Care Center and to its employees for the release of information as specified below.

PURPOSE Communication / Treatment DATE: ______

PATIENT NAME: ______ DATE OF BIRTH: ______

TREATMENT DATES NEEDED: ______ TO ______ (specify month/year)

SPECIFIED REPORTS/EDUCATION INFORMATION: *(Check appropriate boxes)*

[ ] Abstract: face sheet, history & physical, discharge summary, all medical tests, operative section
[ ] All Medical Tests: labs, ECG, x-ray, operative section
[ ] Immunization/Vaccine Information only
[ ] Complete copy
[ ] HIV/AIDS treatment records *(if your information contains HIV/AIDS related information you must check this box)*
[ ] Certified Records
[ ] Drug/Alcohol treatment records Clinic
[ ] Psychiatric treatment records
[ ] Radiology Films
[ ] Genetic
[ ] Discharge Instructions
[ ] Medication Reconciliation
[ ] OTHER: ______

*A fee for copying medical records will be invoiced to the patient or legally authorized representative in accordance with N.J.A.C. § 8:43G- 15.3(d)(1)(2)(i)-(ii), HIPAA Privacy Standard § 164.524 (c) (4). When payment is received the records will be released. ** For continuing care purposes, there will not be a charge for records sent directly to a physician or facility. ** Processing time will vary due to the status of the record.*

RELEASED TO:
Name: Pediatric Psychiatry Collaborative (HUB) Phone: 973-971-4710
Address: ______ Zip: ______
Special Instructions: ______
To be: [ ] Picked up [ ] Mailed [ ] Other ______ Fax 973-383-3506

Unless otherwise revoked by me, this Authorization is **valid for 6 months** from the date above. Revocations MUST be made in writing. Revocation may not be made if action has already been taken in reliance on this Authorization. I have the right to refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, insurance payment or eligibility benefits. When my information is used or shared based on this authorization, the recipient may share it with others and my PHI may no longer be protected by the federal HIPAA Privacy Rule. I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize Primary Care Partners to use or disclose my health information in the manner described above.

Patient Signature ______ Patient Printed Name: ______ Witness ______

If individual is a minor or is otherwise unable to sign this Authorization, please complete the information below:

______ Signature of authorized Legal Guardian, Health Care Agent, or Relationship other authorized Personal Representative

______ Date

______ Signature of Witness