Pediatric Psychiatry Collaborative (PPC)

Atlantic Health Hub at Goryeb Children's Hospital 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) 290-7217

Date of Referral/Contact	_____/_____/_____ ***For Hub use only*** Patient ID: _____ MR #: _____
County	____MORRIS ____PASSAIC
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) 971-4710. 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.