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:** **Symptoms:** **High Risk Factors:** *(Within Past 6 Months)* __Aggression __Anxiety __Homicidal Ideation __Disruptive Behavior __Attention Issues __Inpatient Hospitalization __Emotional Abuse __Changes in Appetite/Weight __Overdose __Legal Problems __Changes in Sleep __Self-injurious behavior __Physical Abuse __Depression __Suicidal Ideation __School Issues __Enuresis/Encopresis __School Refusal __Hyperactivity __Sexual Abuse __Mood Changes __Sleep Problems __Phobias __Social Issues __Psychotic/Delusional Thinking __Substance Abuse __Vocal/Motor Tics __Other: _____
Existing Diagnosis at Time of Consult	__No Psychiatric Diagnoses __Depressive Disorder __Personality Disorder/Trait __ADHD __Eating Disorder __Psychotic Disorder __Adjustment Disorder __Impulse Control, ODD, Conduct Disorder __PTSD/Trauma __Anxiety Disorder __Intellectual, Social, Learning Disability __Autism Spectrum Disorder __Mood Disorder NOS __Bipolar Disorder __OCD __Substance Use Disorder (please identify substance): _____ __Other: _____
Medication History	**List current psychiatric medications:** **List psychiatric medications in patient past history:** _____ _____ _____ _____ _____ _____ __None
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.