THE University of Vermont MEDICAL CENTER

UVM Medical Center Pediatric Psychiatry
1 South Prospect Street, Arnold Level 3
Burlington, VT 05401
FAX: (802) 847-7998 PHONE: (802) 847-4563

# Pediatric Psychiatry Request

Please complete this form in its entirety and fax it to the number above in order to start the referral process. This form along with other paperwork is required to be completed prior to scheduling an appointment.

Date: _____ MRN: _____

Name: _____ DOB: _____ Age: ____ ☐ M ☐ F

Patient's Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Insurance Type: _____

**[Please note: United Behavioral Health(UBH)/Optum insurance coverage for mental health services is required to be paid out of pocket, as our services are currently considered Out-Of-Network.]**

*Parents/Guardians Involved*:

Name/Relationship to patient: _____ Phone #: _____

Name/Relationship to patient: _____ Phone #: _____

Preferred method of contact (circle one): Phone Email USPS

Referring Physician: _____

Primary Care Physician (if different from above): _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Current Psychiatrist or Therapist: _____

Previous, non-psychiatric, medical history (Please attach any relevant labs/studies): _____

_____

Previous psychiatric evaluations/medications: _____

_____

Current Medications: _____

_____

REASON FOR CONSULTATION (Please describe):

*SIGN HERE: _____

Provider's Signature confirming willingness to continue follow up care for this patient

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*Office Use Only:*

*Patient seen before:* ☐ NO ☐ YES Clinician _____ When _____

Packet sent: _____ □ Postal □ Email Deadline for return: _____