

Child & Adolescent Psychiatry Clinic Referral Form



PLEASE PRINT AND USE AS COVER SHEET TO ACCOMPANY OTHER REQUESTED DOCUMENTS.

***Required. Appointment will only be scheduled once all required information has been received.**

*Patient Name _____ *Patient Date of Birth _____
 *Patient Street Address _____ *Patient City/State _____
 *Parent/Guardian Name _____ *Parent/Guardian Phone No. _____
 *Referring Provider Name & Address _____
 *Referring Provider Phone _____ Fax _____
 * Urgent Referral? No Yes If yes, why? _____

PLEASE SEND THE INFORMATION BELOW ALONG WITH THE REFERRAL FORM TO EXPEDITE SCHEDULING.

*Pertinent records/referral letter No Yes: Please FAX
 *Has patient had psychological/neuropsychological testing? No Yes: Please FAX
 *Relationship status of parents: Never Married Married/Partnership Separated Divorced Widowed
 *If applicable, custody agreement (court ordered, CPS, POA): N/A Yes: please FAX
 *If applicable, who has custody? _____
 *Specific symptom/diagnosis for referral _____

Clinic Information:

Child & Adolescent Psychiatry Clinic

310 Old Ivy Way, Suite 104

Phone Number: 434-243-6950

Charlottesville, VA 22903

Fax Number: 434-243-6970

Hours of Operation:

Monday – Friday, 8am – 5pm

Diagnoses Treated in Child & Adolescent Psychiatry		
<ul style="list-style-type: none"> ▪ Depression ▪ Anxiety ▪ Stress ▪ Grief/Loss ▪ LD/ADHD ▪ Anger 	<ul style="list-style-type: none"> ▪ Chronic Illness ▪ Loneliness ▪ Abuse/victimization ▪ Manic Episodes ▪ Obsessions/Compulsions ▪ Trauma 	<ul style="list-style-type: none"> ▪ Relationship Issues ▪ Sexuality/Sexual Issues ▪ Family Conflict ▪ Behavioral Problems ▪ Schizophrenia/Psychosis ▪ Phobias/fears

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