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Center for Interventional Psychiatry and Neurotherapeutics (CIPN)
Form to be filled out by Referring Mental Health Provider

Date: ________________________ Time: ______________________ (referral valid for 30 days)

Patient:____ Date of Birth: _______________

Private Phone #: ____

Referring Provider: MD/DO/NP: ____

Phone:________________Fax:______________Email: __________________________________

Are translation services required? Yes ☐ No ☐

- Please include a copy of your **last progress note** that includes a complete mental status exam, safety assessment, and current treatment plan.
- Please include a copy of patient's updated **demographics** form and/or insurance card.

Identifying Data:

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Current and Past Psychiatric Diagnoses (choose appropriate specifiers):

- ☐ MDD: single episode / recurrent, moderate / severe, with / without psychotic features
- ☐ Bipolar I / II: current episode depressed / manic / mixed, with / without psychotic features
- ☐ Schizophrenia: ____
- ☐ Schizoaffective Disorder: ____
- Active Substance Use Disorders: ____

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- History of Substance Use Disorders: ____

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☐ PTSD ☐ GAD ☐ OCD ☐ Personality Disorders: _______________________

☐ Dementia ☐ MCI ☐ Other: ____

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Cognitive Functioning: □ Intact □ Evidence of Impairment (please elaborate)

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Past Psychiatric History

Hospitalizations ____

Suicide Attempts ____

ECT ____

Transcranial Magnetic Stimulation ____

Dialectical Behavioral Therapy ____

Partial Hospitalization Programs ____

Other therapies, including treatments considered and rejected: ____

Current Medical Problems ____

Past Medical History ____

Past Surgical History ____

Current Psychiatric Medications ☐ None	Current Dose	Adequate Trial	Benefits / Side Effects
		☐ Yes ☐ No ☐ In process	
		☐ Yes ☐ No ☐ In process	
		☐ Yes ☐ No ☐ In process	
		☐ Yes ☐ No ☐ In process	
		☐ Yes ☐ No ☐ In process	
		☐ Yes ☐ No ☐ In process	
		☐ Yes ☐ No ☐ In process	
		☐ Yes ☐ No ☐ In process	
		☐ Yes ☐ No ☐ In process	
		☐ Yes ☐ No ☐ In process	

Past Medication Trials ☐ None	Dose	Adequate Trial	Benefits / Side Effects
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

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Current Non-Psychiatric Medications/Vitamins/OTCs ☐ None	Current Dose

Current Non-Psychiatric Medications/Vitamins/OTCs	Current Dose

Any additional Information you would like us to know:

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The CIPN physicians will be consultants in the care of your patient. While receiving treatment at CIPN your patient will be instructed to contact you for issues related to medication management and psychiatric emergencies. If you have questions about medications, treatment side effects or management of your patient during the treatment series, please feel free to contact our team at 520-874-7500.

Print Attending or Community Psychiatrist name	*Attending or Community Psychiatrist signature*	*Date*	*Time*

Return by **EMAIL** to **BUMCSPsychReferral@BannerHealth.com**
Attention: CIPN Program Coordinator
If you have questions, call the CIPN Program Coordinator at 520-874-7500.