CYC-I CONSULT REQUEST FORM

Call this information into the Intake Line at 855-275-4444 *or fax the information to* 319-356-3715

CYC-I
CHILD & YOUTH PSYCHIATRIC CONSULT PROJECT OF IOWA

Date:	Name of Person Providing information:	Name of Facility:
Clinician's Name:	Phone number to call clinician back:	Best time to reach clinician:

I want the summary of the consult sent to me via:

FAX: Fax #_____

Email:_____

*Please **do not** include any other patient information other than what is request below unless a Consent to Release and Consent to Obtain form is signed by the patient's legal guardian and provided to CYC-I.*

Age _____ **Gender** _____ **Weight** _____ **Height** _____ **BMI**_____

Indicate the reason you are requesting the consult. *Mark all that apply:*

- ❒ Screening
- ❒ Diagnostic
- ❒ Medication Management
- ❒ Multi-model treatment plan
- ❒ Increase confidence
- ❒ Care Coordination
- ❒ Resource Information
- ❒ Other _____

Current Mental Health diagnosis(es)_____

Medical diagnosis (es) _____

Current Medications _____

Previous Medications_____

Please complete the following:

History of Present Illness_____

_____

Social History_____

_____

Family History _____

_____

State the general question you have for the Child Psychiatrist:_____

_____

Insurance:

- ❒ BCBS
- ❒ Other _____
- ❒ United Healthcare
- ❒ Amerigroup
- ❒ AmeriHealth Caritas

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