Please make sure that your CCI Referrals have the following information:

Completed REFERRAL FORM with correct insurance and contact information for the patient

FACE SHEET

Most recent CLINIC NOTE
How do you know if your patient would benefit from the Child Psychiatry Consultation Model?

1. Does your patient have at least one of the following conditions?
   - Depression of mild-moderate severity with/out anxiety
   - Anxiety that has failed a trial of therapy
   - ADHD that has failed 2 trials of medications
   NO → Consider alternate level of care
   YES

2. Does your patient require emergent care?
   - Psychosis
   - Mania
   - Current suicidal thoughts with intent and/or plan
   YES → Refer patient to the emergency room
   NO

3. Would your patient be better suited with long-term psychiatric care due to a past history of one of the following?
   - Bipolar
   - Psychosis
   - Suicide attempt
   - Psychiatric hospitalization
   - Trauma/abuse
   YES → Refer patient for long-term psychiatric care
   NO

4. Is your patient currently using alcohol and/or drugs multiple times a week?
   YES → Substance abuse treatment
   NO

Your patient is appropriate for collaborative management in the CPCM

http://partnershipforchildhealth.org/center-for-collaborative-care/
<table>
<thead>
<tr>
<th><strong>University of Florida Psychiatry</strong></th>
<th><strong>Daniel</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Please <strong>FAX</strong> referral forms and your most recent clinical note to: (904) 383-1660</td>
<td>Please <strong>FAX</strong> referral forms and your most recent clinical note to: (904) 448-7700</td>
</tr>
<tr>
<td>Attention: Sharon Richards</td>
<td>Attention: Julie Riley</td>
</tr>
<tr>
<td><strong>Phone:</strong> (904) 383-1656</td>
<td><strong>Phone:</strong> (904) 296-1055 ext 2761</td>
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<tr>
<td><strong>Locations:</strong></td>
<td><strong>Locations:</strong></td>
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<tr>
<td><strong>DuPont Station</strong>&lt;br&gt;6266 DuPont Station Ct&lt;br&gt;Jacksonville, FL 32217</td>
<td><strong>Daniel Kids</strong>&lt;br&gt;3725 Belfort Rd&lt;br&gt;Jacksonville, FL 32216</td>
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**Now Accepting Referrals:**
- Dr. Kitty Leung, MD
- Dr. Aylin Emmert, MD
- Dr. Victor Santos, MD
- Dr. Allison Nussbaum, MD

**UF Health is “in-network” for:**
- Aetna
- BCBS
- Capitol Health Plan
- Cigna
- GatorCare
- Humana (commercial plans)
- MHNet
- Tricare (Standard)
- United Behavioral Health (Commercial)

**Daniel is “in-network” for:**
- Children’s Medical Services (CMS) Title 19+ 21
- Magellan Complete Care of FL MMA
- Medicaid Molina MMA
- Sunshine Health MMA
- United Behavioral Health (Medicaid)
- Wellcare of FL (Medicaid)

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# Collaborative Care Psychiatry Consultation Request Form

**UF Health:**

Please FAX request form, face sheet and your most recent *clinical note* to **(904) 383-1660**

Attention: Sharon Richards

Phone: **(904) 383-1656**

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**Daniel:**

Please FAX request form, face sheet and your most recent *clinical note* to **(904)-448-7700**

Attention: Julie Riley

Phone: **(904) 296-1055 ext 2761**

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<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date of Birth:</th>
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<tr>
<th>Patient Phone #:</th>
<th>Health Insurance and policy #:</th>
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<th>Patient Primary Language:</th>
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**Service Requested:**

- **Collaborative Care Model:** consultation and up to 3 follow-up visits with plan for patient to return to PRIMARY CARE provider for long-term psychotropic medication management

**Does the patient have a past history of bipolar, psychosis, or psychiatric hospitalization?**

- □ Yes; *If so, please refer instead to Psychiatry for Traditional Care*  □ No

**Is the patient currently using alcohol and/or drugs multiple times a week?**

- □ Yes; *If so, please refer instead for substance abuse treatment*  □ No

**Reason for Consult:**

- □ Depression  □ Anxiety  □ Other (describe):

**Current symptoms of mental illness and changes in school/home functioning:**

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**Has the patient tried psychotropic medication?**

- □ Yes (please list medications)  □ No

**Is the patient currently being treated with psychotherapy?**

- □ Yes (by whom)  □ No

**Score on Patient Health Questionnaire – 9 Item (PHQ9), if relevant:**

**Score on SCARED, if relevant:**

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**Name of Referring PCP:**

Fax# for Referring PCP: Phone# for Referring PCP:  

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