Adult Psychiatry Collaborative Program
Telephone Consultation Request
Please Complete Form and Fax to 518-581-2535

PCP Office - Please fill out the information below regarding your office and patient information.
Upon receipt of this form, Four Winds will call to schedule the telephone consultation.

Physician Name: _____ **Date:**_____

Medical Group: _____ **City:** _____

Phone: _____ **Fax:** _____

Patient Information:

❑Male ❑Female DOB/age: _____ City: _____

Working diagnosis: _____ ❑diagnosis unclear

Allergies: _____ Current Therapist: _____

Does the Patient Have Insurance: ❑Yes ❑No If yes, what insurance: _____

Consultation Question: _____

_____

_____

Current Medication(s):

_____
_____
_____
_____

Previous Medication Trials:

_____
_____
_____
_____

Significant/ Relevant History: (That can be discussed during the telephone consultation)

- Psychiatric History:
- Developmental History:
- Medical History:
- Family Medical/ Psychiatric History:
- Social History:

Information below to be filled out by Four Winds Office Staff Only.

Date Scheduled:_____ Consult Day/Time:_____

PCP Office Contact:_____ Phone Number:_____

Psychiatrist Recommendations: _____

_____

_____

Working Diagnosis:_____ Include list of Outpatient Referral Sources: ❑Yes ❑No

_____ _____

Psychiatrist Signature Date

Case Number:_____ Referral Info. Attached: ❑Yes ❑No