Chapter V.
Treatment Referrals and Follow-up

Guide to the "Treatment Referrals and Follow-Up" Section

Primary Care Clinician Guide to Mental Health Referrals

Forms to Facilitate the Referral Process

Guide to the "Treatment Referrals and Follow-up" Section

Referring depressed youth for treatment and making sure they receive proper follow-up care is a crucial but sometimes complicated endeavor. While many referral arrangements are possible, making sure kids don't fall through the cracks always requires careful planning and clear communication between primary care and mental health providers. This section provides the following tools to facilitate the process of both referring and following-up the care of depressed youth.

Primary Care Clinician Guide to Mental Health Referrals

This section outlines the referral process.

Forms to Facilitate the Referral Process

We provide sample forms to facilitate information sharing between primary care and mental health providers that is compliant with privacy (Canada) and HIPAA (U.S.) regulations.

Primary Care Clinician Guide to Mental Health Referrals

Sequence in Referral Process

1. Primary care provider (PCP) recognizes need for mental health referral.
2. PCP explains reasons for mental health referral and recommends appropriate level of care and type of mental health services (i.e., counselor, psychologist, psychiatrist).
3. Patient and family may not agree to seek help from a mental health specialist. If patient and/or family resists, clinician and/or office staff provides education, offers support and counseling, and reinforces the need for mental health referral.
4. If patient and family are amenable to the referral, a mental health specialist is selected based upon a variety of factors, such as geographic location, insurance coverage, goals of treatment, and whether combined therapy with antidepressants will be used.
5. Once a referral is made, the PCP should complete the Referral form (**Form I**), which will be given to the parent to give to the mental health provider (MHP). This form is designed to be useful even when the name of the MHP is not yet known. On this form, the PCP should include his/her office contact information to facilitate further communication and follow up. If the patient's parent or guardian has not signed the practice's HIPAA-compliant release-of-information form, he/she should sign one at this time. As the parent is giving the form directly to the MHP, no specific releases need to be signed. Alternatively, if the name of the MHP is known, the form can be sent directly to the MHP, providing that specific consent signatures have been obtained. PCPs should consult their own privacy (Canada) or HIPAA (U.S.) advisor.
6. In order to facilitate timely follow-up, the PCP may also provide the MHP with Release of Information and Report Forms (**Forms IIa and IIb). Form IIb** is designed to enable the MHP to promptly communicate basic impressions and recommendations from the evaluation to the PCP after release signatures are obtained. MHPs may need to use their own release forms instead of **Form IIa,** which should be vetted by their own representative before official use. The forms may be adapted.
7. The PCP should obtain consent for ongoing communication with the MHP if the MHP is to provide ongoing treatment.
8. PCPs and MHPs should carefully define and discuss follow-up roles and continue to coordinate patient care until presenting problems are resolved.

FORM I: Referral from Primary Care to Mental Health Provider (to be given to parent by PCP)

Dear Colleague:

I am happy to be referring: _____ on _____ for _____

(Patient's Name- Please Print) (Date) (Reason/Diagnosis)

Summary:

_____

_____

_____

_____

_____

The patient has the following allergies: _____----------

Is on these medications:_____----------

And has these significant health problems: _____----------

The patient had these recent tests:

Lab tests for the following: ____ **CBC** Date: _____ ____**Thyroid Studies** Date: _____
Results: _____ Results: _____

____ **Chem Panel** Date: _____ ____ **EKG** Date: _____
Results: _____ Results: _____

Other:_____

I am I am NOT willing to help manage mental health medications.

***I would like to hear back from you at your earliest convenience. I have attached Forms IIa and IIb to facilitate this feedback.

_____ _____ _____ _____----------

(Provider Signature) (Printed Name and Title) (Phone) (Fax)

Address:_____

FORM IIa: Release of Protected Health Information to Allow Report from MHP to PCP

Dear Parent/Guardian,

Communication between your mental health provider (MHP) and your primary care physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your MHP to share protected health information (PHI) with your PCP. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, lab tests, and medication if necessary.

I, _____, authorize _____, to release protected health information
(Parent/guardian name) (Mental health provider name and address, please print)

related to my child, _____ _____ to:
(Patient name) (Patient date of birth, MM/DD/YY)

_____ _____ _____
(Name and address of primary care provider) (PCP's phone number) (PCP's fax number)

A. I hereby permit the use or disclosure of the above information to the person identified above. I understand that:

1. Only this information may be used and/or disclosed as a result of this authorization.
2. This information is confidential and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be disclosed and would no longer be protected.
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by (insert name of facility/program): _____.

I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my child's protected health information have already taken action because of my earlier authorization.

5. I do not have to sign this authorization and that my refusal to sign will not affect my child's ability to obtain treatment.
6. I have a right to inspect and copy my child's protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR §164.524).

B-1. One-Time Use /Disclosure: I hereby permit the one-time use or disclosure of the information described above to the person identified above. My authorization will expire:

When acted upon

90 days from this date

Other _____

B-2. Periodic Use/Disclosure: I hereby authorize the periodic use/disclosure of the information described above to the person above as often as necessary to fulfill the purpose identified above. My authorization will expire:

When my child is no longer receiving services from (insert name of facility/program) _____

One year from this date

Other _____

C. Parent/Guardian Signature: I certify that I authorize the use of my child's health information as set forth in this document.

Signature of Parent or Guardian: _____ Printed Name: _____

Date: _____

D. Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the parent/guardian of this patient.

Signature of authorized staff person: _____ Printed Name:_____

Date:_____

Form IIb: Report from MHP to PCP

(Information to be provided by mental health provider)

Dear Colleague,

I saw _____ on _____ for _____
(Patient name, please print) (date) (Reason/diagnosis)

Summary:_____
_____
_____
_____
_____
_____
_____

The following medication was or will be started (indicate medication, dosage and other instructions):
_____
_____
_____
_____

If no medication is prescribed, check as appropriate:
_____ Medication not indicated _____ Patient preference _____ Psychotherapy suggested before trying medication
_____Other (specify): _____

Additionally, I recommend
Lab tests for the following: _____ CBC _____ Thyroid studies _____ Chem panel _____EKG

Other treatment recommendations:
_____
_____

___I would ___I would NOT be interested in having you (PCP) help manage mental health medications.

_____ _____ _____ _____
(Provider signature) (Provider printed name) (Phone number) (Fax number)

Address:_____