University of Florida • Department of Psychiatry • Division of Child & Adolescent Psychiatry
North Central Florida Behavioral Health Hub

Patient Referral/Staffing Form

TO BE COMPLETED BY REFERRING PRACTICE:	
Patient Information	
Date:	
Primary Care Practice & Contact Info:	
Referring Provider:	
Patient Name:	
Patient DOB/Age:	Ethnicity:
Patient Gender:	Insurance:
Patient Phone#:	Policy#/Grp#:
Patient Email:	Subscriber name/DOB:
Primary DX:	Additional DXs:
Medication List:	
PSC-17 Scores: I= E= A=	
Other Screener(s):	Scores:
Discussion w/family re: Hub: Y ☐ N ☐	Date:
Reason for Consult: (please specify)	**Documentation Needed:** 1. Release of Information (ROI) 2. Mental Health Background Information 3. Current clinical note to indicate reason for referral 4. Any Psych eval or assessment 5. Scored PSC-17 + all completed screeners (i.e. PHQ-9, GAD-7, SNAP-IV) 6. Court order of guardianship (if needed)
TO BE COMPLETED BY HUB:	
CAP/APRN Assignment-Circle	
Dr. Pumariega | Dr. Soda | Dr. D'Alli	
Dr. Vas | Severance, APRN	
Directive-Circle	
Doc-to-Doc	
Live Evaluation - televideo	
Post Doc Assignment-Circle	
Post Doc	Post Doc Name:
Directive-Circle all that apply	
90791	
Therapy Referral: Y/N	Input BHO:
Additional scales needed: Y/N	List Screener(s):
Notes:	