Pediatric Primary Care Practice Logo

Riverside Community Care
THE HELP YOU NEED CLOSE TO HOME

PROTOCOLS
MANAGING [PEDIATRIC PRIMARY CARE PRACTICE] CASES REFERRED TO RIVERSIDE CLINICS

REFERRAL MANAGEMENT PROCESS

<u>This process covers urgent and routine referrals</u>. Please note that if you have a psychiatric emergency, please contact the Psychiatric Emergency Team in your area (see list for the phone numbers of those teams).

Following is the flow based upon the type of referral

Urgent Referral	Referring Pediatric Practice very concerned about child; danger not imminent though heightened concern exists; with parent/guardian calling directly – very high anxiety about child needing to be seen very quickly. (Case example – 14 year old boy increasingly agitated; thoughts of hurting self revealed, no plan nor history of suicide attempts). **[Pediatric Primary Care Practice] <u>calls and faxes</u> completed Referral Form to Riverside clinic** Appointment within 2 – 3 business days is offered by Riverside Notification to Practice of appointment status via faxed **Status of Referral Form**: Patient never accepts appointment nor contacts Riverside –notice within 1 business day Patient accepts appointment, does not keep the appointment – notice same day as appointment Patient keeps Initial Intake appointment – sent within 2 business days Please note that initial appointment is with a therapist, not a psychiatrist
Routine Referral	[Pediatric Primary Care Practice] faxes a completed **Referral Form** to the Riverside Clinic Appointment within 10 business days is offered by Riverside Notification to Practice of appointment status (by fax): Patient never accepts appointment nor contacts Riverside – **Status of Referral Form** within 2 weeks after outreach Patient accepts appointment, does not keep the appointment – **Status of Referral Form** within 2 weeks of missed appointment after outreach attempt Patient keeps Initial Intake appointment – **Status of Referral Form** sent within 1 week of appointment Please note that initial appointment is with a therapist, not a psychiatrist
During Episode of Care	
Communication of Evaluation/Plan from Riverside to Practice	**Initial Evaluation Form and Treatment Plan** faxed to practice within 4 weeks of appointment (assuming release of information signed).

When medication is needed in addition to therapy	For child/youth enrolled in therapy, Riverside therapist refers to Riverside psychiatrist for medication evaluation. Riverside prescriber will call pediatrician within 3 business days of determination of any regimen of psychotropic medication If referring pediatrician believes medication need is urgent (or wants medication consult only), pediatrician has the option to contact MCPAP (Massachusetts Child Psychiatry Access Project). Where appropriate, Riverside clinician will facilitate coordination among the clinic, pediatric practice and MCPAP. ***Please note: Riverside does not provide medication only services to children***
If significant change in or reassessment of child's condition occurs	When either Riverside or the Pediatric Practice becomes aware of a significant development with immediate impact on the child's mental health status or treatment, notification to the other party should occur as soon as is possible via telephone.
Communication at Discharge	
Discharge Summary	If a Riverside prescriber has been involved and if the medication management initiated by Riverside will be continued by the Pediatric Practice, then the prescriber will communicate with the pediatrician prior to discharge. **Discharge Summary Form** faxed to practice after the patient's discharge as soon as possible, within 45 days.

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DATE of REFERRAL
_____

RIVERSIDE COMMUNITY CARE
ADDRESS/ PHONE/ FAX

Referral Form

URGENT	☐
ROUTINE	☐

CLIENT NAME: _____ **Date of Birth:** _____

Address: _____

Preferred Phone Number:_____**Other Phone Number:**_____

Is it safe to call and leave a message? Yes ☐ No ☐

Mother's Name:_____**Father's Name:** _____

Guardian's Name:_____**Language Spoken at Home:** _____

Insurance:_____**Subscriber ID#:** _____

Subscriber Name:_____**Subscriber Employer:** _____

Referring Clinician Name:_____**Referral Contact Person**:_____

Primary Care Physician Name (if different from referring clinician):_____
Referral has been discussed w ith parents/ guardian: **Yes ☐ No ☐**

Practice Name:_____**Phone:**_____**Fax:** _____

REASON FOR REFERRAL
State the reason for the referral and any questions you would like answered.

Presenting problems and symptoms and work-up results thus far:

Medication History (include attempts at medication by physician):

Other pertinent information:

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TODAY'S DATE
_____

RIVERSIDE COMMUNITY CARE
ADDRESS/ PHONE/ FAX

Status of Referral Form

CLIENT NAME:_____ **Date of Birth:** _____

Date of Original Referral:_____ **Riverside Contact Person:**_____

Practice Name:_____ **Phone:**_____ **Fax:** _____

Referring Clinician Name:_____ **Referral Contact Person**:_____

Primary Care Physician Name (if different from referring clinician):_____

ORIGINAL REFERRAL TYPE: **URGENT** ☐ **ROUTINE** ☐

URGENT Referral - Update

1. ***Patient never accepted appointment or contacted Riverside*** _____(check)
2. Patient accepted the appointment but did not keep — Missed Appointment Date_____
3. Patient accepted and kept the Initial Intake appointment — Appointment Date_____-____

Riverside Brief Status Update:_____

_____

_____

ROUTINE Referral - Update

1. ***Patient never accepted appointment or contacted Riverside*** _____(check)
2. Patient accepted the appointment but did not keep — Missed Appointment Date_____
3. Patient accepted and kept the Initial Intake appointment — Appointment Date_____

Riverside Brief Status Update:_____

_____

_____

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TODAY'S DATE
_____

RIVERSIDE COMMUNITY CARE
ADDRESS/ PHONE/ FAX

Initial Evaluation and Treatment Plan

CLIENT NAME:_____ **Date of Birth:** _____

Date of Original Referral:_____ **Original Referral Type: URGENT** ☐ **ROUTINE** ☐

PCP Practice Name:_____ **Phone:**_____ **Fax:** _____

Referring Clinician Name:_____ **Referral Contact Person:**_____

Primary Care Physician Name (if different from referring clinician):_____

ASSESSMENT (Please reference referring clinician's original reason for referral):

INITIAL DIAGNOSIS:
Axis 1:
Axis 2:

INITIAL TREATMENT PLAN:

Therapist Name:_____
Is Client referred to Psychiatric Evaluation? Yes___No____

Clinician Signature:_____

Date of Next Appointment: _____
Name of Psychiatrist: _____
Date of Psychiatry Appointment:_____
Date:_____

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RIVERSIDE COMMUNITY CARE DISCHARGE SUMMARY

Client Name: ____ Case Number: _
Date of Birth: _____
Intake Date: _____ Discharge Date: _____

Identifying Data and Formulation:

_____

Course in Treatment:

Diagnosis Axis I: _____
Diagnosis Axis II: _____

Discharge Medications

Discharge Plan

Phone: ☐ OR
Letter: ☐

Discharge Dispositions

☐ Outpatient Clinic
☐ Primary Care
☐ Day Treatment
☐ Club House
☐ School
☐ Employment
☐ Volunteer Services
☐ Other Agency

☐ Medical Reason
☐ Hospice
☐ Moved out of Area
☐ AMA
☐ Hospital
☐ Death
☐ Sub. Ab. Program
☐ Self Help Group

☐ Goals Attained

☐ Other

Clinician Signature:_____Date: _____

Riverside Community Care

RELEASE/REQUEST

CONFIDENTIAL INFORMATION

PERSON SERVED:_____**DOB**:_____**RECORD #**: _____

Riverside Community Care is authorized to **Release to**: _____

Person/Organization

_____ _____ _____

Address of Person/Organization Telephone # Fax #

And/Or - Circle one or both

Riverside Community Care is authorized to **Request from**: _____

Person/Organization

_____ _____ _____

Address of Person/Organization Telephone # Fax #

The following information and/or documents:

- ❑ Admission Summary
- ❑ Discharge Summary
- ❑ Clinical Treatment
- ❑ Substance Abuse/Treatment (I understand that all related information is protected under Federal and State law and I have the right to refuse release)_____

  Person Served/Parent/Guardian's Signature
- ❑ Psychiatric/Medication Evaluation
- ❑ Psychological Tests
- ❑ Treatment Planning Information
- ❑ Employment Related Information
- ❑ Consults
- ❑ Other_____
- ❑ HIV Related Information (I understand that all related information is protected under Federal Law and that I have the right to refuse release)_____

  Person Served/Parent/Guardian's Signature
- ❑ **Verbal/Telephone Communication**

  RE: _____

For the PURPOSE of:

- ❑ Evaluation/Intake
- ❑ Discharge/Aftercare Planning
- ❑ Treatment Planning
- ❑ Other _____

Legal Matter (specify): _____

This Authorization Expires on:_____(1 Year From Consent)

It is my understanding that this information will be used solely for the purpose described above. I understand that I may revoke my permission at any time except after the information has already been released, and to the extent that action has been taken in reliance on it.

Person Served/Parent/Guardian Signature:_____Date:_____

Witness:_____Date:_____

REFUSAL:

I do **not** authorize Riverside Community Care to release information at this time.

Person Served/Parent/Guardian Signature:_____Date:_____

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