CALLOWHILL FAMILY THERAPY, PC
REQUEST FOR PSYCHIATRIC EVALUATION

DATE:_____

NAME:_____AGE:_____

REFERRED BY {NAME:}_____
THERAPIST/PHYSICIAN/OTHER

REASON FOR REQUEST: ANXIETY DEPRESSION
POOR SLEEP PANIC
INABILITY TO FUNCTION
OTHER:_____

CLIENT ACCEPTS THERAPY:_____REFUSES:_____

CLIENT WILLING TO TAKE MEDS:_____REFUSES:_____
CURRENT MEDICATIONS: {NAMES & DOSAGES}
BRING MEDICATIONS ALONG TO EVALUATIONS

_____

_____

_____

PREVIOUS PSYCH HISTORY – INPATIENT OR OUTPATIENT
HOSPITAL OR FACILITY:_____

_____

DIAGNOSIS:_____

_____

_____

_____

THERAPIST'S TX GOALS:_____

_____

_____

_____

X X

_____

Client's/Guardian Signature: DATE

Authorization # and Amount of Med Checks_____# of med cks_____

BY MY SIGNATURE BELOW, I UNDERSTAND THAT FAILURE TO CANCEL AN APPOINTMENT WITH THE DOCTOR WITH LESS THAN 24 HOURS NOTICE WILL RESULT IN A CHARGE OF $120.00 FOR THE INITIAL EVALUATION OR $55.00 FOR A MEDICATION CHECK.

X X

_____

SIGNATURE/CLIENT OR GUARDIAN DATE

Callowhill Family Therapy, PC
244 North Fifth Street
Reading, PA 19601

Phone: 610-372-8822 Fax: 610-372-6626

CONSENT FOR TREATMENT WITH MEDICATION

The psychiatrist has informed me that she recommends that I receive medication and therapy for the treatment of my illness. I have been informed of the nature of the treatment, and the risks of possible side effects, potential benefits and alternative forms of treatment.

I understand that I should inform the doctor or office staff if there are any problems, reactions and/or changes in my condition, which may be, related to this medication.

I understand that I do not have to take this medication. My physician believes that this medication is likely to help me but is unable to give me a guarantee of its' effectiveness.

I understand that the information on the patient information leaflet is selective, for use as an educational aid and does not cover all of the possible uses, actions, precautions, side effects or interactions of this medications with other prescribed or over the counter medications. I understand that further information can and should be provided by my pharmacist at the time the prescription is filled. I further understand that this form does not provide specific medical advice for individual medical problems, however, it provides official acknowledgement that I have been provided knowledge of the medications that have been prescribed for me by the psychiatrist.

On this basis, by my signature below, I authorize the psychiatrist or anyone authorized by the psychiatrist to prescribe these medications at such intervals as recommended.

Initial and date which medication information was distributed to the patient.

Medication	Date & Initial	Medication	Date & Initial	Medication	Date & Initial
Ritalin		Wellbutrin		Tegretol	
Dexedrine		Antiparkinson		Lithium	
Cylert		MAO Inhibitor		Risperdal	
Benzodiazepines		Neuroleptics		Ambien	
Buspar		Sleep Aids		Effexor	
Vistaril/Atarax		SSRI Agents		Others:	
Tricyclic		Clorazil			
Desyrel		Depakote/Depakane			

Check All That Apply

- ☐ Possible side effects of the medication(s) were explained and discussed with me.
- ☐ The reason for the prescribed medication(s) were explained to me.
- ☐ Risks of pregnancy while taking psychotropic medication(s) have been explained to me.
- ☐ I have expressed understanding of the issues regarding the prescribed medication(s).

Patient / Guardian Signature	Date	Psychiatrist	Date