Behavioral Care Solutions, LLC and Geriatric Psychiatric Services, PLLC
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CONSULTATION REQUEST, CONSENT AND AUTHORIZATION TO TREAT

Resident Name:	Facility:	Room:	Licensed Clinician Ordering Services:
Type of Referral: ☐ Psychiatric and Psychological ☐ Other _____			Date:

Reason for Referral Checklist *(check all that apply):*

☐ **Psychotropics -** Resident currently on or has past history of psychotropic medication use (medication management)	☐ **Psychosocial Status Change** (i.e., death of family member, decreased socialization, etc.)
☐ **Psychiatric Diagnosis -** Past or current history of psychiatric diagnosis and/or hospitalization	☐ **Resistance to Care** and/or refusal of care or participation in treatment
☐ **Mental Status** issues/change (**please explain below** - suicidal ideation, cognition issues, sadness, anxiousness)	☐ **Medical Diagnosis** that requires adjunctive behavioral care (weight loss secondary to diabetes, chronic pain, etc)
☐ **Behavioral** issue (**please explain below**)	☐ **Family Issues/Conflict**
☐ **Adjustment Difficulties** to current living environment	☐ **Discharge Difficulties** due to Psychiatric Issues
☐ **Adverse Status Change** in nutrition, activity participation, vegetative functions, sleep	☐ **Other**
Explanation	

Treatment Description. In making this referral BCS is requested and authorized by order of the attending physician to use any necessary diagnostic tools to diagnose and treat the above named patient as a psychiatric and psychological/psychosocial referral (unless otherwise stated). In the case of psychiatric evaluation, treatment might include the prescription of psychotropic medication or if the patient is already receiving psychotropic medication, treatment might include its continuation. The psychiatric consultant will determine whether medication is or remains necessary based upon a thorough evaluation of the patient's past and recent history and behavioral status (corresponding with one or more specific psychiatric diagnosis and targeted symptoms). A determination to prescribe or continue such medication will be further based on careful consideration of the possible benefits/intended outcomes of treatment, possible risks and side effects, alternative forms of treatment, and the possible consequences of not receiving such medication treatment. It is important to understand that the consequences of the use of psychotropic medication cannot always be predicted for any given individual and there is a chance the patient may not react favorably to its administration. There is a possibility that the medication may need to be changed or the dose adjusted over time. It is also important to understand that you can at any time withdraw your consent and request that the psychotropic medication be discontinued. A facility representative can contact you and advise you of any new medication treatment or changes to the current medication regimen following the initial evaluation by the psychiatric consultant. In the case of psychological or psychosocial treatment, services might include an evaluation, psychotherapeutic interventions and behavioral planning, testing and continuing follow-up, as needed.

Consent to Release Health Information. The Consenter designated below authorizes BCS to release any personal health information pertaining to diagnosis and treatment to any insurance company or third party who undertakes responsibility for BCS's professional service fees. The Consenter hereby authorizes full payment of the insured portion of the charges to be paid directly to BCS and understands that any portion of the fee not covered by insurance is the responsibility of the patient.

Statement of Consent. ☐ **I DO CONSENT** to the treatment designated herein, including necessary recommended psychotropic medication treatment other than _____ (no exclusion unless specified). I give consent voluntarily and without coercive or undue influence. I understand this consent may be revoked at any time.

☐ **I DO NOT CONSENT** to the treatment designated herein. I understand that, as a result of my refusal to consent, I absolve the facility and its employees and contractors from any liability or responsibility for anything that might happen to me as a result of this refusal. This refusal to consent also may make it necessary to transfer me to another healthcare facility as a result of my psychiatric condition.

Resident's Signature and Date (**In Person, if available**)	Authorized Representative Signature, Date and Relationship (**In Person, if available**) Relationship:

Telephone Consent if Patient/Responsible Party Unavailable to Sign

Name of Person Giving Consent and Relationship: _____

Signature and Title of Person Who Obtained Consent / Completed Form: _____ (Print Name and Title Here)	Date: