Salt Lake County
Division of Substance Abuse Services

REFERRAL FOR MEDICATION EVALUATION

Name of Referring Agency: _____
Name of Referring Licensed Mental Health Professional:_____
Full Address of Agency:_____
_____
Client's Full Name:_____ MIS Number:_____
Client's Social Security Number:_____ Date of Birth:_____
Client's Last Known Address:_____
County:_____ State:_____
Client's Funding Code:_____ ASAM Level:_____
Date Client Entered Treatment: _____ Date of Last Use of Alcohol and/or Drugs: _____

Presenting problem and reason for referral: _____
_____
_____
_____

Please list all medications the client currently is taking including over the counter meds:

Medication	Dose	Frequency	Prescribing MD	Phone Number

Please list all psychiatric medication the client has been prescribed in the past:

Medication	Dose	Frequency	Prescribing MD	Phone Number

Please check all that apply:

Behavior:	Mood:	Affect:	Mental Status:
___ withdrawn/isolating	___ poor concentration	___ flat	___ auditory hallucinations
___ acting out	___ helpless	___ inappropriate	___ paranoia
___ suicidal	___ hopeless	___ blunted	___ visual hallucinations
___ tearful	___ sad	___ labile	___ delusions
___ peculiar	___ anxious	___ normal	___ memory difficulties
___ excessive sleep	___ angry		___ racing thoughts
___ difficulty sleeping	___ irritable		___ inappropriate speed
___ excessive energy	___ euphoric		
___ change in appetite	___ depressed		
___ history of violence			

Referral must be signed by a Licensed Mental Health Professional and include a two-way release of information.

It is my clinical impression that the above referred client has a mental illness and requires a medication evaluation.

_____ _____
Signature of Mental Health Professional Phone Number

_____ _____
Contact Person (If Different) Phone Number

Angie Twitchell
Cornerstone
PH: 355-2846
Fax: 359-3244