

## Psychiatric Collaborative Consultation

| General Information    |                          |               |                               |
|------------------------|--------------------------|---------------|-------------------------------|
| Patient Name:          | DOB:                     | Address:      | Date of appointment:          |
| Guardian:              |                          | Address:      | Phone number:                 |
| Residential Provider:  | Vocational/Day Provider: |               | Staff Present at appointment: |
| Primary Care Provider: | Address:                 | Phone Number: |                               |
| Therapist:             | Address:                 | Phone Number: |                               |

| Medical   |                      |
|---|----------------------|
| Diagnosis:  | Medication to treat: |
| Diagnosis:  | Medication to treat: |
| Diagnosis:  | Medication to treat: |
| Height:   | Pulse:               |
| Weight:   | Respirations:        |
| B/P:  | Laboratories:        |
| Allergies: <ul style="list-style-type: none"> <li>• Environmental:</li> <li>• Food:</li> <li>• Medication:</li> </ul> |                      |
| Health related changes since last appointment (other important information):<br><br><br>                              |                      |

| <b>Therapist Treatment Plan</b>           |
|---|
| Long Term Goal and Short Term objectives: |
| Evidence Based Practice Utilized:         |
| Progress towards outcomes:                |

| <b>Behavioral</b>   |
|---|
| Behavioral concerns (i.e hallucinations, suicidal, homicidal, aggression, psychosis):   |
| Assessment Tools to include Functional Behavioral Assessment (FBA):   |
| General Events Reports or Incident Reports (provide summary of all GER's from Therap or of incident reports) for the past 6 months or from last appointment:  |
| Behavioral Support Plan Data: <ul style="list-style-type: none"> <li>• Provide a copy of the individuals current behavioral support plan for residential and vocational</li> <li>• In the chart below: Provide the number of intervals (i.e. hours) in which the client engaged in use of their replacement behavior (RB) i.e. appropriate requests for attention, tangibles, or escape during that reporting period.</li> <li>• In the chart below: Provide the number of intervals the client engaged in target behaviors during that reporting period: physical aggression (PA), property destruction (PD), self-</li> </ul> |



| Psychiatric Provider to Complete |
|----------------------------------|
| Assessment:                      |
| Plan:                            |
| Follow Up:                       |

| Consultation Form Completed by: | Name/Title | Date: |
|---------------------------------|------------|-------|
| Provider:                       |            |       |
| Therapist:                      |            |       |
| Doctor:                         |            |       |