

UW Psychiatry and Addiction Case Consultation

Patient Case Consultation Request Form – please print clearly

Provider Name	Date of Request	Reason for Consultation Request		
Provider Email	Provider Phone	Clinic Name; City; Zip		
Patient Information				
Age / Gender	Relationship Status	Housing Status	Employment Status	
Current Psychiatric Diagnoses		Relevant Medical Diagnoses / Problems		
Current Medications		Prior Psychiatric Medication Trials		
Psychiatric History				
Suicidal Ideation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:		
Suicide Attempts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number / Date / Severity:		
Psychosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:		
Mania	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:		
Trauma/Abuse History	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:		
Prior Psychiatric Admissions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number / Date:		
Family Psychiatric History	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:		
Substance Use History				
		Last Used	Frequency / Pattern of Use	
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Opiates	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Marijuana	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Benzodiazepines	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Nicotine	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Stimulants	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Intravenous drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
History Withdrawal symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Describe:	
Prior Substance Use Treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Describe:	
Looked up in Prescription Monitoring Program?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Describe results:	
History of DUI?			Describe:	
Laboratory and Rating Scale Values				
Value / Date	Value / Date	Value / Date	Value / Date	Value / Date
PHQ-9:	ASRS:	CBC:	HCV:	Lipid:
GAD-7:	SDS:	UTox:	A1c:	
Audit-C:	TSH:	LFT:	ECG/QTc:	Other:

Please contact Diana Roll at uwpacc@uw.edu or 206-221-1355 for questions.