KPEP Kaiser Permanente Group Referral

E-mail Completed form to: scal-bh-panel@kp.org

Date of Referral: _____

Patient Name: _____ MRN: _____

DOB: _____ Best number to reach patient: _____

Medical center area of Patient: _____

Diagnosis: _____

Reason for referral/Major Presenting Problems:

Current SMART goals and progress toward goals and or barriers to progress:

Internal and external resources currently utilized in this episode of care (e.g., medication, groups, AA, therapy, DMC, IOP, community resource):

Most Recent TPI scores:

BHI _____ GAD _____ PHQ9 _____ CSSRS_____

Primary Concern includes:

Tx for chronic or acute symptoms causing major impairment in current functioning
Management of Mild to Moderate Symptoms of depression and or anxiety
Adjunctive Tx for mild depression (PHQ9 score of 5-19)
Adjunctive Tx for mild anxiety (GAD 7 score of 5-14 if PHQ9 of 5-19)
Grief/Bereavement
Autism/Social Skills
Disordered Eating
Other: _____

Any other pertinent information: _____

Initial Assessment has been completed on Tridiuum

Patient agrees to a group referral

Referring provider:

Group Practice (if applicable): _____

Phone number: _____

E-mail address: _____