KPEP Kaiser Permanente Medication Consultation 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: _____

Reason for referral/Major Presenting Problems:

Diagnosis: _____

Most Recent TPI scores:

BHI _____ GAD _____ PHQ9 _____ CSSRS _____

Primary Concern includes:

Tx for chronic or acute symptoms causing major impairment in current functioning
For Mild to Moderate Symptoms
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)
ADHD evaluation --Non-Complicated ADHD
ADHD evaluation for --Complicated ADHD
Previous Failed PCP (Primary Care Provider) medication trials
KP MediCal patient

Any other pertinent information: _____

Initial Assessment has been completed on Triduum
Patient agrees to a medication referral

Referring provider: _____

Group Practice (if applicable): _____

Phone number: _____

E-mail address: _____