

# First Appointment Request Form

## **Please read the following Instructions on requesting an Intake Appointment at Lifespan Psychiatric Consulting, LLC.**

Thank you for your interest in Lifespan Psychiatric Consulting! We want to help you find the right services with the practitioner best suited for you. Our clinicians have different areas of specialty and varying availabilities. Because of this, we have created this process for reviewing your request and determining whether we have the right practitioner to help you achieve your goals.

*Please note that it is possible for availability to change from one day to the next, so we may not be able to provide you with an accurate prediction of availability until you submit this form. Below are instructions and important information on our process:*

- 1. You** complete the Appointment Request Form below.
- 2. Our clinicians** review the information to see if they are a good match to meet your needs with their specialties/availability.
- 3. Our Office Manager** will contact you within 5-7 business days of your submission to update you if there is a clinician available who meets your needs or to refer you to another practice that may better serve you.

### **Important Information:**

- A referral from another provider does not guarantee an appointment at Lifespan and does not expedite the intake process.
- After you submit your request, you should expect contact within 5-7 business days. Please call or use our secure email contact form if you have not heard from us after 7 business days.
- If you are thinking of harming yourself or others or are having a mental health crisis you may call 911 or the Multnomah County crisis line at 503-988-4888. Please note that completing this form does not ensure services including urgent services.
- The initial appointments are intended to be assessments in which you & our clinicians decide and discuss if our services will be able to help you achieve your goals. It is possible that the initial, or ongoing, appointment(s) may result in a referral to another practitioner thought to be more appropriate for your needs.
- This form is secure and HIPAA compliant.

*\*\*By continuing and completing this form, you are agreeing and acknowledge that you understand the above information.*

Today's Date: \_\_\_\_\_

**Patient Information:** \*fields followed by an asterisk are required or the request will not be reviewed.

**Patient's Name\*:**

First: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_

Patient's Pronouns: \_\_\_\_\_

**Date of Birth\*:** \_\_\_\_\_

**Patient Gender as is on insurance\*** \_\_\_\_\_

**Identified Gender (If different)** \_\_\_\_\_

**Patient's Physical Address\***

Street Address: \_\_\_\_\_ Apt/Building \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

**Is The Above Listed Address A Group/Foster Home? \***

Yes

No

## Who should be contacted regarding this appointment?

**Contact's Name** (Write 'self' if patient) \*

First: \_\_\_\_\_ Last: \_\_\_\_\_

### **Relationship\***

- Self
- Parent/Guardian
- Spouse/Partner
- Sibling
- Relative
- Primary Care Provider
- Current Therapist
- Case Manager / Navigator / Social Worker
- Friend

**Contact's Phone\*:** \_\_\_\_\_

**Contact's Email:** \_\_\_\_\_

**Can Lifespan respond to your request at the given email? \***

*(If no, we will call using the phone number provided above.)*

Yes

No

Are you taking mental health medications? \*

Yes (Please list):

No

Name of person or clinic that is currently prescribing these medications:

Are you current in therapy or seeing a mental health professional (e.g. therapist or psychologist, psychiatrist, PMHNP)? (Circle one):

Yes

No

Name of therapist or mental health professional:

**Insurance Company / Network\*\*\*\*:** \_\_\_\_\_

Member ID#: \_\_\_\_\_

Group #: \_\_\_\_\_

Subscriber / Primary insured on plan:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Benefits & Eligibility Phone number (see back of card): \_\_\_\_\_

**We do not accept any form of Medicare or Medicaid**

**Referred by\*:**

Self referred

**Or choose one and write name in blank:**

Primary Care Physician \_\_\_\_\_

Therapist \_\_\_\_\_

Other: \_\_\_\_\_

**Services Being Requested\* (Choose at least one)**

Medication Management

Counseling

**Primary Reason for Appointment\*: \*\*\*\*\*REQUIRED\*\*\*\*\***

*In as much detail as possible, please describe what you are currently experiencing and why you are looking for services at this time. The clearer you are, the better we will be able to place you with a practitioner who is available and suited to help you best.*

**I would like to request specific provider(s):**

- Andrew Vilius PMHNP
- Patrick Lohse PMHNP
- Leslie Wright PMHNP
- Molly Turner, PMHNP

**Do you have a clinical diagnosis? \***

- Yes (Please list)
- No

**Are you currently taking any Mental Health Medications? \***

- Yes (Please list)
- No

**Do you consider this an urgent matter?**

- Yes
- No

*\*\*If you are currently in crisis, please be aware we cannot provide you with immediate care. Please call 911 or the Multnomah County crisis line at 503-988-4888.*

**Please use this space to provide us with any additional information you wish to share that was not aptly covered by this form:**

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