YOU'RE NOT ALONE PSYCHIATRY / Lisa E. Hake, MD : Referral Form

You’re Not Alone Psychiatry

Provider Referral Form

FORM DESCRIPTION / INTRODUCTION

Copy and paste:

> **Thank you for referring your patient to You’re Not Alone Psychiatry.**
>
> This brief form helps Dr. Lisa E. Hake understand your referral question and determine whether the patient may be a good fit for the practice.
>
> You’re Not Alone Psychiatry provides scheduled outpatient psychiatric care for adults in Oregon and is not an emergency or crisis service. This form is not monitored continuously. For urgent or emergency psychiatric needs, please use appropriate crisis or emergency services.

SECTION 1 — PATIENT INFORMATION

1. Patient name

Field type: Short answer
Required: YES
Question:

> Patient name

2. Date of birth

Field type: Date, if Practice Better offers it; otherwise Short answer
Required: YES
Question:

> Date of birth

3. Phone

Field type: Short answer
Required: YES
Question:

> Patient phone number

4. Email

Field type: Short answer / Email, if available
Required: YES
Question:

Patient email address

5. Pronouns

Field type: Short answer
Required: NO
Question:

Pronouns (optional)

I would **not** create a pick list here. A short response is simpler and avoids needing an exhaustive list.

6. Insurance

Field type: Multiple choice
Required: YES
Question:

Current insurance/payment method

Choices:

- Regence BlueCross BlueShield
- Traditional Medicare
- Private pay
- Other / Unknown

If Practice Better lets **Other** generate a write-in field, use that.

SECTION 2 — REFERRING CLINICIAN

7. Name and credentials

Field type: Short answer
Required: YES

Referring clinician — name and credentials

8. Practice/organization

Field type: Short answer
Required: YES

Practice or organization

9. Phone

Field type: Short answer
Required: YES

Phone number

10. Fax

Field type: Short answer
Required: NO

Fax number

11. Secure email

Field type: Short answer / Email
Required: NO

Secure email address

I wouldn't require both fax and email. You primarily need **one reliable way of getting back to them**, and you've already required their phone.

SECTION 3 — HOW CAN I HELP?

This is the heart of the referral.

12. Reason for referral

Field type: CHECKBOXES
Required: YES

Because they can select more than one.

Question:

What are you referring this patient for? Please select all that apply.

Choices:

- Comprehensive psychiatric evaluation
- Diagnostic clarification
- Medication evaluation / management
- Depression
- Anxiety / panic
- Mood / bipolar concerns
- ADHD / attention concerns
- Trauma-related symptoms
- Sleep concerns
- Medication side effects or inadequate treatment response
- Deprescribing / medication simplification
- Geriatric psychiatric concerns
- Psychotherapy
- Integrative / lifestyle psychiatry
- Other

Have **Other** open a write-in field if Practice Better permits that.

13. The referral question

Field type: Long answer
Required: YES

What would you most like Dr. Hake to help with?

I would make this required. In fact, if someone completes almost nothing else clinically, **this is what you need to know**.

SECTION 4 — HELPFUL CLINICAL INFORMATION

Here's where I would make most things **optional**. We're deliberately avoiding turning this into a second intake form.

14. Diagnoses

Field type: Long answer
Required: NO

Known or suspected psychiatric diagnoses, if known

15. Psychiatric medications

Field type: Long answer
Required: NO

Current psychiatric medications and important previous medication trials, side effects, or adverse reactions, if known

Don't make a medication table. That's exactly the kind of thing that makes a referral form burdensome.

16. Relevant medical information

Field type: Long answer
Required: NO

Relevant medical or neurologic conditions, if known

17. Anything else?

Field type: Long answer
Required: NO

Is there anything else you think would be helpful for Dr. Hake to know?

I really like retaining this question. It gives the referring clinician somewhere to put the **human context** that doesn't fit into our categories.

SECTION 5 — SAFETY

I would make this required because it is directly relevant to whether your telepsychiatry practice is an appropriate level of care.

18. Current/recent safety concerns

Field type: CHECKBOXES
Required: YES
Question:

To your knowledge, are any of the following current or recent concerns? Please select all that apply.

Choices:

- No current or recent safety concerns known
- Suicidal ideation or self-harm
- Recent psychiatric hospitalization
- Substance-related concern
- Aggression or violence concern
- Other significant safety concern
- Unknown / insufficient information

Important: I added **Unknown / insufficient information**. A referring PCP may not actually know. We don't want someone checking “none” simply because the form requires an answer.

19. Safety details

Field type: Long answer
Required: NO

Please provide any relevant details about safety concerns:

If Practice Better allows **conditional questions**, this would be ideal: only display it when they select something other than “none” or “unknown.” That's a good question for your meeting.

SECTION 6 — RECORDS & CARE COORDINATION

20. Records available

Field type: CHECKBOXES
Required: NO

What additional records are being provided or are available? Please select all that apply.

Choices:

- Medication list
- Recent clinical notes
- Relevant laboratory results
- Previous psychiatric evaluation or testing
- Hospital / discharge records
- Other
- No additional records

21. Upload records

Field type: File upload — **IF Practice Better allows this on a publicly linked form**
Required: NO

Upload relevant records, if desired.

This is one of the things to specifically test today. If an outside provider can securely upload PDFs here, **that's excellent**.

22. Primary care clinician

Field type: Short answer
Required: NO

> Primary care clinician, if known

23. Referral date

I actually think we can **eliminate this question** if Practice Better automatically timestamps the submission. There's no reason to make someone enter information the system already knows.

FINAL ACKNOWLEDGMENT

I would add one final required item.

23. Acknowledgment

Field type: Checkbox or required Yes/No
Required: YES

> I understand that You’re Not Alone Psychiatry provides scheduled outpatient psychiatric care and that submitting this referral does not guarantee acceptance into the practice.

☐ I understand

I would **not** put a statement here requiring the provider to certify that the patient has signed an ROI. Whether an authorization is required depends on the circumstances and HIPAA's treatment-related disclosure provisions; we don't need to turn your referral form into a legal attestation.

Then:

> **Thank you for your referral.**
> Lisa E. Hake, MD
> You’re Not Alone Psychiatry, LLC

Thank you for referring your patient to You’re Not Alone Psychiatry.

This brief form helps Dr. Lisa E. Hake understand your referral question and determine whether the patient may be a good fit for the practice.

You’re Not Alone Psychiatry provides scheduled outpatient psychiatric care for adults in Oregon and is not an emergency or crisis service. This form is not monitored continuously. For urgent or emergency psychiatric needs, please use appropriate crisis or emergency services.

SECTION 1: PATIENT INFORMATION

Patient

Legal first name

Last name

Preferred Name

Middle Name

Home Phone

Mobile Phone

Email Address

Date of Birth

Gender

Pronouns

Insurance

- ◯ Regence BlueCross BlueShield
- ◯ Traditional Medicare
- ◯ Private Pay
- ◯ Other

If 'Other', please (specify):

SECTION 2: REFERRING CLINICIAN

Name and Credentials

Practice / Organization

Phone

Fax or Secure email

SECTION 3: HOW CAN I HELP?

What are you referring this patient for?

Please select all that apply.

- ☐ Comprehensive psychiatric evaluation
- ☐ Medication evaluation / management
- ☐ Anxiety / Panic
- ☐ ADHD / attention concerns
- ☐ Sleep concerns
- ☐ Deprescribing / medication simplification
- ☐ Psychotherapy
- ☐ Diagnostic clarification
- ☐ Depression
- ☐ Mood / bipolar concerns
- ☐ Trauma-related symptoms
- ☐ Medication side effects or inadequate treatment response
- ☐ Geriatric psychiatric concerns
- ☐ Integrative / lifestyle psychiatry

Other

What would you most like Dr. Hake to help with?

SECTION 4: HELPFUL CLINICAL INFORMATION

Known or suspected psychiatric diagnoses, if known

Current psychiatric medications and important previous medication trials, side effects, or adverse reactions, if known

Relevant medical or neurologic conditions, if known

Is there anything else you think would be helpful for Dr. Hake to know?

SECTION 5: SAFETY

To your knowledge, are any of the following current or recent concerns?

Please select all that apply.

- ☐ No current or recent safety concerns known
- ☐ Suicidal ideation or self-harm
- ☐ Recent psychiatric hospitalization
- ☐ Substance-related concern
- ☐ Aggression or violence concern
- ☐ Other significant safety concern
- ☐ Unknown / insufficient information

Please provide any relevant details about safety concerns:

SECTION 6: RECORDS & CARE COORDINATION

What additional records are being provided or are available?

Please select all that apply.

- ☐ Medication list
- ☐ Relevant laboratory results
- ☐ Hospital / discharge records
- ☐ Recent clinical notes
- ☐ Previous psychiatric evaluation or testing
- ☐ No additional records

Primary care clinician, if know

FINAL ACKNOWLEDGMENT

Thank you for your referral.
Lisa E. Hake, MD
You’re Not Alone Psychiatry, LLC

Thank you for your referral.

- ☐ I understand that You’re Not Alone Psychiatry provides scheduled outpatient psychiatric care and that submitting this referral does not guarantee acceptance into the practice.