UPMC | WESTERN BEHAVIORAL HEALTH

Center for Interventional Psychiatry (CIP) Referral Form

(To be completed by the referring OP psychiatrist or CRNP, or an assigned designee)

Thank you for reaching out to the UPMC Center for Interventional Psychiatry (CIP). CIP provides several treatment options for patients with treatment-resistant depression and other neuropsychiatric disorders.

After reviewing the referral, we will contact the patient to schedule a consultation appointment. During this consultation, the patient will meet with a CIP psychiatrist who can provide more information about our treatment options.

You can find more information about our treatment options, including educational videos, at UPMC.com/CIP.

Thank you for considering UPMC Western Psychiatric Hospital and Center for Interventional Psychiatry for your patient's care.

Referral Instructions

Please complete the following referral form. These questions will help us determine any treatment options for which your patient is eligible and the options that best fit their needs.

In addition to the completed referral form, please provide the following patient information:

- **Complete list of prescription and over-the-counter medications, including dietary supplements**
- **Three most recent progress notes or psychiatric evaluations**
- **Any EKG tests performed in the past six months (for ECT referrals only)**
- **All current insurance information (Note: TMS is not currently covered by Medicaid)**

Send completed referral form and additional documents to:

Fax: **412-246-5065**
Email: **cip@UPMC.edu**

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Imprint Patient Information Here

Please indicate treatment preference below:

☐ Electroconvulsive therapy (ECT) ☐ Transcranial magnetic stimulation (TMS) ☐ Esketamine

Referral Date:

Referring Psychiatrist/CRNP Information

Name: (First) (Last)

Phone number: Fax number:

Email:

Patient Information

Name: (First) (Last)

DOB: (mm/dd/yyyy) Height: Weight:

MRN: SSN:

Preferred phone number: Secondary phone number:

Email:

Address:

City: State: Zip:

Insurance provider:

Phone number:

ID #: Group #:

Secondary insurance provider:

Phone number:

ID #: Group #:

Emergency Contact Information

Name:

Phone number: Relationship to patient:

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Patient Psychiatric Information

Psychiatric diagnosis:

Does the patient carry a diagnosis of any of the following? (If yes, please describe.)

Bipolar disorder: ◯ No ◯ Yes

Schizophrenia: ◯ No ◯ Yes

Schizoaffective disorder*: ◯ No ◯ Yes

*Esketamine and TMS are only approved for MDD, single/recurrent episodes without psychosis.

Substance Use Disorder or Actively Using Substances: ◯ No ◯ Yes (If yes, please specify Substances.)

*If medical marijuana provide card copy and indication: How Much: Last Use:

*Note all services require abstinence from substances

Has this patient received ECT in the past? ◯ No ◯ Yes

If yes, when/how many sessions? Location:

Has this patient received TMS in the past? ◯ No ◯ Yes (If yes, please describe the response or any problems.)

If any progress notes are in Cerner or Epic, please list the dates the patient was seen:

Current medical conditions:

Does patient have a history of any of the following conditions?

☐ Uncontrolled hypertension ☐ Head injury ☐ Severe cardiac disease ☐ CVA

☐ Aneurysmal disorder ☐ Severe liver disorder ☐ Epilepsy or seizures

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Current medications (psychiatric and medical):

Name of medication	Dosage	Duration

Previous psychiatric medication trials:

Name of medication	Dosage	Duration

Does the patient have metal in their brain/skull or elsewhere in their body (e.g., splinters/clips, etc.)?
◯ No ◯ Yes (If yes, specify the type of metal and location.)

Does the patient have an implanted neurostimulator (e.g., DBS, epidural/subdural/VNS)?
◯ No ◯ Yes (If yes, specify the type of metal and location.)

Does the patient have a cardiac pacemaker or intracardiac lines? ◯ No ◯ Yes (If yes, please specify.)

Does the patient have a medication infusion device? ◯ No ◯ Yes (If yes, please specify.)

Additional past treatments or therapy:

Additional comments

Signature: _____ Date: _____ Time: _____
(Signature of person completing form)

Print: _____ Date: _____ Time: _____
(Printed Name of person completing form)

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