Referring Clinician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinician Phone: (\_\_\_\_\_\_\_)-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

Clinician Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Affiliation (e.g. Hospital, Clinic):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient DOB: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_
Patient Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Up to date contact number for scheduling appointment: (\_\_\_\_\_\_\_)-\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comorbid Medical Diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Substance Use Disorders (y/n, if yes specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications:

|  |  |
| --- | --- |
| Medication | Dose-for LAIs include last admin date |
|  |  |
|  |  |
|  |  |

History of psychiatric hospitalization: (y/n): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes approximate dates and where hospitalized:

History of suicide attempts (y/n, if yes, include when) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family/friends Involvement in care (y/n, include relationship and contact information) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please select reason(s) for referral (select all that apply):

[ ] Consultation only (e.g. diagnostic clarification, medication recommendations)

[ ] Medication management

[ ] Clozapine Clinic

[ ] Injection Clinic

[ ] Psychotherapy

[ ] Family

[ ] Individual

[ ] First episode care (pt is within first 3 years of onset of illness)

Steps to Scheduling an Evaluation/Intake Appointment

1. Confirm patient has been registered at Boston Medical Center
	* Call (617)-414-6060 to register if the patient is **NEW** to BMC
	* Make a PCP appointment upon registration
2. Send medical records. If patient has been hospitalized within the past month, need most recent discharge summary. Securely email that information along with the referral form to the contact below:
	* Email: WRAP@bmc.org
	* Call our clinic coordinator, Ellie, at 617-858-1421 with any questions
3. Once referral has been reviewed and approved, we will call the patient directly to schedule in the WRAP clinic.
	* For reference: Adult Clinic: -(617)-414-4238
	Child Clinic (17 and younger): -(617)-414-4561

Questions/Concerns:

Always call **911** in case of a medical emergency or immediate safety concern.

Call the **BEST** Team for 24 Hour Psychiatric Crisis (800)-981-HELP (4357)

Call Ellie Reagan for questions about WRAP Clinic including but not limited to:

* Rescheduling an appointment
* Directions to our offices
* Hearing more about any of the services we provide
* Other questions about the clinic

Phone (google voice): 617-858-1421