SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

Telepsychiatry Consult Request Form
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Patient Name	DOB		
Please list phone numbers provide by family/other support in			
For patients under 18yo, parent/guardian/DSS case manager must provide a phone number they will agree to answer Number for telepsychiatry to call when ready to see the patient Check appropriate box to indicate if this an initial or a follow-up consult.			
		Initial Consult—check items included with this red	quest
		Face Sheet/Admission Information	Lab results
Physician/attending notes	X-ray/CT scan/EKG or other test results		
Nursing notes	Copies of suicide note/email/text/social media		
Notes from EMT/police/family	List of medications given in the ED		
Follow-up Consult—check items included; initial c	onsult information is not needed		
Face Sheet/Admission Information	Physician notes since last consult only		
Labs results done since last consult	Nursing notes since last consult only		
List of medications given since last consult.	Sitter notes since last consult only		
Check all that are related to the reason for this consult: Odd behaviorHallucinations, A&VDelusions/paranoiaInability to care for selfIntoxicated on/withdrawing from alcohol or drugsRequesting treatment for substance use d/oDetention order or Part IOther	Suicidal ideation/attemptR/O Suicide attempt—unclear circumstancesHomicidal ideationAggressive/threatening behavior before and/or in the EDPt's condition has improved, please reassess72-hour re-evaluation		
Question for Consult			