University of Washington Medical Center
Psychiatric Outpatient Clinic

Resident Waitlist Referral Form

Thank you for considering this referral to the resident continuity care clinic at UWPOC. Completion of this form will help you to determine eligibility of your patient for treatment services by one of our psychiatry or psychology residents. Please review the information below. If eligible, your patient will be placed on our Resident Waitlist for care. COMPLETION OF THIS FORM DOES NOT GUARANTEE PLACEMENT IN THE CLINIC. It only assures placement on the Resident Waitlist. Review of this referral will be done by the Clinic Triage Team weekly meeting. Until your patient has been assigned a resident, the clinic WILL NOT assume psychiatric/psychological care of your patient.

CRITERIA FOR TREATMENT IN RESIDENT CONTINUITY CARE CLINIC:

-history or high likelihood of compliance with outpatient care
-adequate social supports
-no active alcohol or substance abuse/dependence
-if history of alcohol or substance abuse/dependence, has been clean and sober for **at least 6 months,** and is motivated to remain clean and sober
-ability to wait for up to **two months** for assignment with resident for care
-does not need free care (has mental health benefits through insurance)
-does not need case management
-does not need social work services
-is not requesting care in context of court ordered treatment or is seeking care as part of parole, less restrictive orders (LRO), or other legal/forensic situation

If your patient meets the above criteria, then do the following:

1. discuss with your patient the option of being placed on the Resident Waitlist for care
2. Review the **WAITLIST PROCEDURE** document (lavender sheet) with the patient and give it to the patient. It contains relevant information for the patient and has clinic contact information so that patient may check their status on the Resident Waitlist.
3. Dictate your note with your findings and recommendations and also include that you have discussed the **WAITLIST PROCEDURE** with the patient, given them the document, and whether patient voiced understanding of this process.
4. Complete the form on the back of this page to outline requested services and recommendations.
5. Place this form in the Treatment Recommendations box in the mailroom, or if referring from another clinic **fax to 206-598-7794** or send via campus mail to **UWPOC Triage Team, Box 354694.**

The form lists the predominant forms of psychiatric and psychological interventions offered at UWPOC. However, if you identify a patient that may benefit from a form of intervention not listed (e.g. couples therapy, Dialectic Behavioral Therapy-DBT) and wonder if there is a resident interested and available to participate in that intervention please contact the **Chief Resident** regarding availability of a resident or resident interest.

Finally, please note, because the resident continuity care clinic is a teaching clinic, the number of residents and the amount of time they have in clinic varies. Thus, availability for taking on new patients varies. There will be times the resident continuity care clinic may be full and your patient's time on the Resident Waitlist may expire before placement.

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Date: _____ Evaluating Clinician: _____

Patient Name: _____
Telephone #: _____
Medical Record #:_____

PRESENTING COMPLAINT:_____
DIAGNOSIS: Axis I: _____
_____
Axis II: _____
Axis III: _____

EVALUATING CLINICIAN TREATMENT RECOMMENDATIONS:

Check (✓) modality that applies:
___ Medication Management ___ Psychotherapy
___ Combined Medication Management with Psychotherapy

Check (✓) psychotherapies that may be indicated:
___ Supportive Therapy ___ Cognitive Behavioral Therapy (CBT)
___ Brief Analytic/Psychodynamic Psychotherapy (BAP)
___ Cognitive Behavioral Analysis System of Psychotherapy (CBASP)
___ Interpersonal Psychotherapy (IPT) ___Other: _____

Please circle patient available times:

Monday	**Tuesday**	**Wed**	**Thurs**	**Friday**
AM	AM	AM	AM	AM
PM	PM	PM	PM	PM

Additional patient information:
_____
_____
_____

For office use only- do not write in this area

Mental health coverage (provider, benefits, exclusions, phone #): _____
_____
Triage Team Recommendation: _____
_____
_____