COLUMBIA | PSYCHIATRY

Columbia Day Program Referral Form *(Page 1 of 2)*

Dear referring/collaborating clinician,

Thank you for referring your patient to the Columbia Day Program (CDP). Please fill this form and email it back to our office at your earliest convenience. Your input is important to help our team effectively evaluate, develop appropriate treatment goals, and determine what groups your patient will be referred to. If you have any questions or concerns, please do not hesitate to contact our intake coordinator at (212) 326-8437. Thank you!
The CDP Treatment Team

Patient Name _____ Patient DOB: _____

Please list all DSM V Diagnoses *(please include comorbidities, especially any substance use issues)*:

☐ Anorexia
☐ ADHD
☐ Autism Spectrum Disorder
☐ Bipolar Disorder
☐ Borderline Personality Disorder
☐ Bulimia
☐ Generalized Anxiety Disorder
☐ Major Depressive Disorder
☐ OCD
☐ Panic Disorder
☐ PTSD
☐ Psychotic Disorder
☐ Narcissistic Personality Disorder
☐ Schizophrenia
☐ Social Anxiety Disorder
☐ Substance Use Issues
☐ Other/s (please specify) _____

Most prominent symptoms for this patient *(check all that apply)*:

☐ Anhedonia
☐ Anxiety
☐ Agitation/irritability
☐ Low energy
☐ Low Mood
☐ Non-suicidal self-injury
☐ Insomnia/hypersomnia
☐ Interpersonal issues
☐ Suicidal ideation

With respect to current presentation, please characterize the following *(check one for each)*:

Acuity/Risk
☐ Low
☐ Moderate
☐ High

Treatment Resistance
☐ Low
☐ Moderate
☐ High

Duration of Current Episode
☐ Short
☐ Moderate
☐ Prolonged

How frequently do you meet with this patient? **Less than weekly** ▼

If there are any other providers on this treatment team, please list names and contact information here:

Are you, or another clinician already on the treatment team, able to meet with this patient for weekly individual therapy while they participate in the Columbia Day Program? **No** ▼

Concerns or possible contraindications for group therapy *(e.g., issues with emotional regulation, tolerating interpersonal issues, previous issues in group therapy, etc)*:

5 Columbus Circle, 6th Floor, New York, NY 10019
Telephone: 212.326.8437 Fax: 212.326.8590
www.columbiadoctors.org/dayprogram

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Columbia Day Program Referral Form *(Page 2 of 2)*

Patient Name _____ Patient DOB: _____

Groups that may be a good fit with your patient *(check all that apply)*:

☐ Acceptance and Commitment Therapy
☐ Behavioral Parent Training for Parents of Young Adults
☐ BIPOC Support Group
☐ Cognitive Behavioral Therapy for Depression
☐ Cognitive Behavioral Therapy for Anxiety (Generalized Anxiety)
☐ Cognitive Behavioral Therapy for Anxiety (Intrusive Thoughts and OCD related issues)
☐ Dialectical Behavior Therapy
☐ Executive Functioning
☐ Gender Identity and Sexuality Support Group
☐ Mindfulness Based Stress Reduction
☐ Substance Use Group (Harm Reduction)
☐ Substance Use Group (Abstinence focused)
☐ Support/Process Group
☐ Trauma Group (Phase 1 - Safety and Stabilization)

Medications

Medication	Maximum Dose	Response (partial/none/full)	Side Effects

Do you believe both in-person and online groups would be a good for your patient?

☐ Yes
☐ No (if no, please tell us more) _____

In a few words, what are your goals for the patient if they attend the CDP?

Any other comments you would like us to know:

_____ _____
Referring clinician name Date

_____ _____
Contact Number Email Address

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