Tampa General Hospital Behavioral Health Hub Telepsychiatry Referral Form for Providers
eFax number:

Referral Request Type

☐ Physician-to-Physician Consultation
15-30 minutes
☐ Collaborative Psychiatric Evaluation
60 minutes

Referring Provider Information

Practice Name:

_____

Current Provider: _____

Office Contact: _____

Phone Number: _____

Date of Referral: _____ / _____ / _____

Patient Information

- Full Name: _____ Date of Birth: ____ / ____ / _____
- Parent/Guardian Name(s): _____
- Phone and email contact: _____
- Is the child in state custody (e.g., foster care)? ☐ Yes ☐ No
- Health Plan Name: _____ Policy/Group Number _____
- Medicaid ID (if applicable): _____
- Gender: ☐ Male ☐ Female ☐ Non-Binary/Other

- Preferred
  Name: _____
  _____
- Race/Ethnicity:
  ☐ White ☐ Black ☐ Hispanic/Latinx ☐ Asian ☐ Other: _____

PCP's Reason for Consult:

_____
_____
_____
_____
_____

Medical & Dental History

- Date of Last Physical Exam: ____ / ____ / _____
- Are vaccinations up to date? ☐ Yes ☐ No
- Allergies: ☐ Yes ☐ No
  If yes, list all known allergies (medications, supplements, foods, environmental): _____
  _____
  _____
- Medical Diagnoses: ☐ Yes ☐ No ☐ Unknown, if yes, check all that apply:
  ☐ Asthma ☐ Diabetes ☐ Obesity ☐ Cardiovascular disease
  ☐ Hyperlipidemia ☐ High Blood Pressure ☐ Low Blood Pressure
- ☐ Dizziness or Fainting ☐ Convulsions/Seizures/Epilepsy ☐ Head Injury
  ☐ Hearining Problems ☐ Loss of Consciousness ☐ Respiratory Illness
  ☐ Urogenital Problems ☐ Vision Problems ☐ Other:
  _____
- Previous history of surgery, please describe and give dates:
  _____
  _____
  _____

- If your child has had any serious injuries, please describe and give dates:
  _____
  _____
  _____
- Biological females only, if your child has started menstruation, at what age?_____
- Are periods regular? ☐ Yes ☐ No

Current Physical Health Medications :(Attach additional pages if needed)

Name of Medication	Dose of medication	Duration of Treatment	Who is the prescri

- Please list any medications the child has taken in the past:
  _____
  _____
  _____
- Routine Dental Visits? ☐ Yes ☐ No
- Date of Last Dental Visit: ____ / ____ / _____

Consent for Medical Care, Telemedicine, and Telepsychiatry

By signing below, I acknowledge and agree with the following:

- I consent to and authorize Florida Health Sciences Center (FHSC) dba Tampa General Hospital (TGH), the University of South Florida (USF), my physicians, and health care providers (collectively "my providers") to provide or order medical care, diagnostic and laboratory procedures, and prescribe medicinal drugs that my providers determine to be necessary.
- I understand that TGH is affiliated with a teaching institution, USF, and that residents, interns, students, and other individuals may observe or participate in my care, treatment, and services ("Care").
- I consent to TGH taking photographs and/or video/audio recordings of me during and related to my Care, and to the use of such media and my medical data for educational purposes within TGH. I authorize TGH to retain, preserve, use for educational purposes, or otherwise dispose of any specimens, tissues, medical devices, or implants removed from my body during my Care.

Telemedicine and Telepsychiatry

- I understand and agree that my providers may use telemedicine, including videoconferencing, electronic transmission of imaging, and remote monitoring of vital signs, as part of my Care. Except in emergencies, my providers will explain the risks and benefits of telemedicine prior to the encounter. I understand that I have the right to seek in-person Care instead of a telemedicine encounter.

Telepsychiatry Consent

I acknowledge and agree that:

- Telepsychiatry is subject to the same privacy laws as in-person care.
- A resident physician may observe the session.
- This consent is valid for one (1) year from the date of signature.
- I may withdraw consent at any time without affecting my or my child's care.

- I may request access to and copies of information from the telepsychiatry session.
- No specific outcomes are guaranteed.

Potential Risks of Telepsychiatry

- Possible delays in evaluation or treatment due to technical issues.
- Rare risk of data breach despite security protocols.

Authorization for Release and Use of Health Information

I authorize **TGH** and my providers to release my health information, including information related to mental health/psychiatric care, alcohol and/or substance abuse, genetic testing, and HIV tests, for purposes of treatment, research, and/or to obtain payment for charges incurred by me or on my behalf. This information may be released to:

- My providers or affiliated providers
- Referring or treating providers
- Third parties engaged in medication data collection or dissemination
- The guarantor on my accounts
- Third-party payors (e.g., Medicare, Medicaid, Tri-care, insurance companies, workers' compensation, HMOs, self-insured employers, and sponsors) or their agents
- Researchers or research entities
- Regional or national health information networks
- Other providers of medical services or products related to this admission or Care

I also authorize TGH to disclose my information to:

- Business associates, public health and oversight agencies, and regulatory entities

- Other health care providers or organizations involved in my Care for operational purposes
- Residents, interns, students, and others for educational and/or research purposes
- Disaster relief agencies as needed
- Law enforcement for identification or crime reporting
- Affiliated charitable foundations for fundraising purposes
- TGH for sending health-promoting or informational materials

If my admission or treatment is related to a motor vehicle accident, I authorize TGH or my providers to obtain a copy of my "crash report" as required by Florida Statutes to facilitate third-party payment.

I understand that my patient information is protected by the right to privacy guaranteed by **Article 1, Section 23 of the Florida Constitution**. I do not authorize the release of my patient information—including redacted versions—if requested by other patients or their representatives.

Emergency Protocol
In the event of a behavioral health emergency, the pediatric or provider site will follow its established emergency procedures.

Consent to Telepsychiatry
I, the parent/legal guardian, have read and understood the information above. I have had the opportunity to ask questions, and all have been answered to my satisfaction. I hereby give informed consent for the use of telepsychiatry in my child's care.

- **Authorized Practice**
  Name: _____
  _____

- **Parent/Legal Guardian Name (Print): _____ _____**
- **Signature: _____ _____ Date: ____ / _____ / _____**
- **Witness Name: _____ _ Witness Date: ___ / ___ / _____**
- **Copy of Consent Form Offered (Initials): _____**
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