PEER REVIEW REFERRAL FORM

Please complete this form and send it as a [secure] email to your paired practitioner.

Your Name: _____

Your Email Address: _____

Your supervising psychiatrist or nurse practitioner: _____

Agency that your work for:

☐ DMH (DMH directly-operated program)

☐ Other (please describe): _____

Please provide the name and medical record number of one patient that has had at least an initial evaluation and two follow-ups in the past six months.

Patient Name: _____

IBHIS or Other Medical Record Number: _____

If the patient is a child or adolescent, is he or she involved in the Foster Care System?

☐ Yes ☐ No