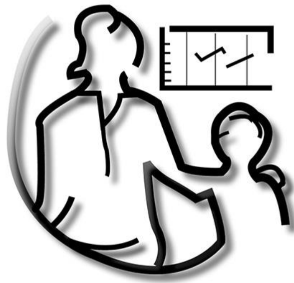

APMRT

Alabama Psychiatric Medication Review Team

A Collaboration between
Auburn University Department of Psychology & AL-DHR

Medication Review Services Referral Form

Instructions: Please complete entire form, save, and email to
APMRT@auburn.edu *or* and fax to (334) 844-6659

CHILD INFORMATION

Child's First & Last Name: ______________________________ **Age**: __________

DOB: __________________ **Origin County:** ______________________________

Gender: _________________ **Height:** ________________ **Weight:** ________________

Please attach Child's CFA: Yes, CFA is attached ☐

Does the child have a written behavior plan? **YES** **NO** *(If yes, please attach.)*

Diagnoses:

1. ____
2. ____
3. ____
4. ____
5. ____

Check the appropriate box for other services that the child is receiving:

☐ Applied Behavior Analysis (ABA) services
☐ Counseling
☐ Play Therapy
Parent-Child Interaction Therapy (PCIT)
☐ Occupational Therapy (OT)
☐ Speech Therapy
☐ Other: ____

BEHAVIOR PROBLEMS

Behavior	Where Behavior Occurs	How Frequently Behavior Occurs	Notes
Example: Aggression	At school	5x/week	Aggression directed at peers and staff

OTHER CONCERNS

Check the appropriate box for the child's other concerns:

- ☐ Asthma
- ☐ Seizures
- ☐ Tourette syndrome
- ☐ Low IQ
- ☐ Diabetes
- ☐ Exposure to drugs or alcohol during pregnancy
- ☐ Obesity
- ☐ Sleep problems
- ☐ Toileting issues
- ☐ Other: ____________________

MEDICATIONS

Name of Prescription	Reason for Prescription	Dosage	Time of Administration	Name of Prescriber
Example: Vyvanse	ADHD	40 mg	7:00 AM, 12:00 PM	Peter Lusche, MD

Please list any recent medication changes (within the last 1-2 months):
Examples: medication added, removed, increased, or decreased; change in administration time

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

5. ______________________________

Lab work within the last 2-3 months (if applicable):

Depakote Level	Date:	Level:
	Date:	Level:
	Date:	Level:
Lithium Level	Date:	Level:
	Date:	Level:
	Date:	Level:
Thyroid Panel	Date:	Level:
	Date:	Level:
	Date:	Level:
Blood Sugar	Date:	Level:
	Date:	Level:
	Date:	Level:
Hemoglobin A1C (HgA1C)	Date:	Level:
	Date:	Level:
	Date:	Level:
Sodium Level	Date:	Level:
	Date:	Level:
	Date:	Level:

CAREGIVER INFORMATION

(if applicable)

Caregiver(s) Name(s): ____

Address: ____

Email(s): ____

Contact Phone Number(s): ____

Caregiver was informed that referral has been made: Yes ☐ No ☐

FACILITY INFORMATION

(if applicable)

Facility Name: ____

Address: ____

Facility Contact Person(s): ____

Contact Phone Number(s): ____

Contact Email: ____

DHR CASEWORKER INFORMATION

Caseworker Name: ____

Email: ____

Phone Number: ____

Supervisor Name: ____

Email: ____

Submit referrals through email or fax
Email: APMRT@auburn.edu
Fax: (334) 844-6657
Phone: (334) 844-6659