Gulf Coast Consultation in Child and Adolescent Psychiatry

Provider Background Form

Name:

Your provider identification number (entered by team):_____

Practice Name **Practice Zip Code**

Office Backline Phone Number **Email Address**

Gender:

Number of years in practice:

Residency training:

Any specialty training? No Yes

Board certification: None ABP ABFP other

Number of MDs in practice: **Number NPs in practice:**

Approximate percentage of children in your practice who have public insurance:

Please rate your perception of the Oil Spill has affected your practice

	Substantial increase	Increase	No Change	Decrease	Substantial decrease
Patient Volume					
Patient Family Stress					
Patient family violence					
Patient mental health severity					
Patient mental health prevalence					
Provider/staff stress					

Comments:____

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Please let us know if you have specific requests for continuing education programs or resources you would like from this project. Thanks!

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Participant Agreement

I understand that GCAP is a consultation program and that the consultants will not take over responsibility for the care of my patients or prescribe medications. I agree to continue to manage behavioral health care of patients whose needs can be met in the primary care setting following consultation with the team.
I agree to participate in the program evaluation by completing baseline and follow-up surveys.

Signature Date