



**tcmhcc**  
Texas Child Mental  
Health Care Consortium

**CPAN**  
Child Psychiatry  
Access Network

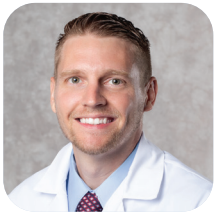
**PeriPAN**  
Perinatal Psychiatry  
Access Network



**UT Tyler**  
**HEALTH SCIENCE  
CENTER**

# Child & Perinatal Psychiatry Access Network (CPAN/PeriPAN)

## Northeast Texas Staff



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For more information or to enroll, call **888-901-2726**, choose option 1, then option 3.

# Requesting CPAN and PeriPAN Services

If you are a medical provider in Northeast Texas, you can request CPAN or PeriPAN services by calling **888-901-2726**, choose option 1, then option 3.

## Hotline



Scan the QR code provided to have our **CPAN/PeriPAN Hotline** number saved as a contact in your phone.

## Text Only



Enrolled providers and their staff may also request services via text at **903-502-1351**. Scan the QR code provided to have our **CPAN/PeriPAN Text Only** number saved as a contact in your phone. No patient PHI should be shared via text.

*CPAN/PeriPAN does not provide emergency care. If a patient is in crisis, call 988 instead.*

### The following information will be required from callers requesting services:

- **Enrolled provider's name**
- **Clinic name**
- **Reason for call** (Example: Questions about medication management, screening, resources, referrals, etc.)
- **Callback telephone number**
  - This is the number the CPAN/PeriPAN team will use when returning a consultation request from a clinician and/or providing follow-up on referral/resource information. This can be a cell phone or clinic/landline number.
    - If a cell phone number is provided, please ensure the phone is turned **ON** to enable us to deliver a quick response. (Using a cell phone for callbacks is preferred.)
    - If a clinic/landline number is provided, please include a contact name to ask for when we call back. We want to ensure the call does not go to voicemail.
- **Preferred method of receiving referral/resource information**
  - This is how we will send resources and/or referral information to you after it has been validated by our team. (Example: email, text, fax) We **do not** include any patient PHI in our responses.
- **Required patient information**
  - First and last name (or initials)
  - Date of birth
  - Medical record number
  - Gender
  - Race/ethnicity
  - Family/home zip code
  - Name of insurance plan, if any (for verifying referrals)

*Please note: If a therapy referral is requested, we may ask for additional information to ensure the patient receives the appropriate modality.*