ADOLESCENT IOP/PHP REFERRAL

PATIENT LAST NAME _____ **FIRST NAME** _____

IDENTIFYING INFORMATION

Date of Birth: ____/____/_____ **Race/Ethnicity:** _____ **Preferred Language:** _____

Identifying Gender: ☐ Male ☐ Female ☐ Other: _____
Gender Assigned at Birth: ☐ Male ☐ Female
Preferred Pronouns: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Other: _____

Current Diagnosis:

_____

_____

Current symptoms:

_____

_____

_____

Current level of functional impairment:

_____

_____

_____

Alcohol/drug use, history:

_____

_____

Current Medications:

_____ _____ _____

_____ _____ _____

Risk Assessment completed? ☐ Yes ☐ No
Current risk level: ☐ low ☐ moderate ☐ high
How determined: _____

Referral discussed with patient? ☐ Yes ☐ No
Patient/family agreed with referral? ☐ Yes ☐ No

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_____ _____
Referring provider printed name Date of referral

_____
Referring provider signature

Referral received and reviewed:

_____ _____
Staff printed name Date

_____
Staff signature

Disposition: ☐ patient accepted ☐ patient not appropriate for program

Other:_____