Intensive Outpatient Program (IOP) Referral Form

onvida Health

PART A: PATIENT INFORMATION

Date: **Time:** **Staff Taking Call:**

Caller Name/Title: **Phone #:**

Caller Company: **Address:**

Patient Referred By:

Patient Name: **Male:** **Female:** **Age:** **DOB:**

Address: **City:** **Zip Code:**

Phone #: **Alternate Phone #:**

Primary Insurance: # **Secondary Insurance:** #

DPOA/Guardian Name: **Relationship:** **Phone #:**

PART B: PRE-ADMISSION ASSESSMENT

Reason For Referral: _____

_____

_____

_____

Current Psychiatric Provider: _____ **Phone:** _____

Previous Inpatient Psychiatric Hospitalization (include dates): _____

_____

Medications (Include Non-Prescription): _____

_____

_____

Current Medical Condition and/or Diagnosis(s): _____

_____

_____

Admission Criteria (Check all that apply)**:**

- ☐ Emotional disorder, in DSM 5, of such severity to require intensive treatment without inpatient or IOP level of treatment
- ☐ Requires intensive follow-up from inpatient hospitalization/ or partial hospitalization program
- ☐ Psychiatric symptoms significantly impair social, occupational, or other important areas of functioning
- ☐ Failed less intensive level of care
- ☐ Sleep/nutrition disturbance poses risk
- ☐ Planned services are reasonably expected to improve or maintain the individual's condition and functional level to prevent relapse
- ☐ Patient would otherwise require admission to an inpatient hospital or continued treatment in an inpatient or partial hospitalization service
- ☐ On-going medication management/psychiatric care needed for being maintained in community setting
- ☐ Medication withdrawal change toxic effects or non-compliance
- ☐ Other (*describe*):