Adolescent Intensive Outpatient Services Referral Form
Email completed form to: phi@sabhc.org

PLEASE PRINT

Date	Chart Number [Staff Only]
Last Name	First Name
Gender	Date of Birth
School Grade	History of IEP Y / N
Custodial Parent/Legal Guardian Name	Contact Information
Referring Provider Name	Contact Information
Primary Language	Insurance

Behavioral Diagnoses (if applicable):

Recent Concerns/Presenting Problem (Attach most recent clinical assessment or hospital discharge summary, if applicable):

Recent Safety Concerns, including non-suicidal self-injurious behavior and/or aggressive behavior (Acute SI/HI not appropriate for IOP):

Substance Use History (if applicable):

Trauma History:

Social History/Risk Factors:

Medical History (Please include any allergies):

Medication List (Minimum 2-week supply of medication should be supplied by referring provider prior to client entering IOP):

Other Comments/Concerns:

Staff Only:

Disposition: ◯ Accepted ◯ Not Accepted ◯ Capacity Enrollment
Acuity Score:
Reviewer Signature/Date: