Catalpa Health Intensive Services Referral Form

Fax (920) 882-5484 442 N. Westhill Blvd. Appleton, WI 54914

Patient Name: _____ DOB: _____

School: _____

Patient's Insurance(s): Primary _____ Secondary _____

Patient's Diagnoses: Primary _____ Secondary _____

Date of Referral: _____ Referred By: _____

Family is aware of, and in agreement with intensive services referral: ☐YES ☐NO

Symptom	**Current, Past, Never**	**Description (if "Current" or "Past" symptoms)**
Psychotic symptoms		
Suicidal		
Violent		
Police contact		
Poor school functioning		
Difficulties functioning in community		
Difficulties functioning at home or in a family environment		
Multiple hospitalizations in last 3 months		
Disordered Eating		
Substance Use		

Current - symptoms within 30 days; Past - no symptoms in last 30 days; Never - symptoms never occurred

Referral Information

Why is the client being referred to intensive outpatient services? (Please explain why this level of care is appropriate)

_____

_____

_____

What is the client's history of treatment (outpatient, inpatient, in home, groups, intensive levels of care)?

Who are the client's current providers (PCP, psychiatry, therapy, other)?

What progress has the client made with the current treating provider?

What is the client's living arrangement? (Custody and placement arrangements)

What goals do you see as appropriate for intensive outpatient services?

What barriers, if any, are present that could impact the client receiving services in an intensive outpatient program? (i.e., transportation, parent motivation, living environment, etc.)

Please attach the following records:

If referred by a **mental health clinician**: Initial Evaluation, Tx Plan, and last 3 progress notes

If referred by a **school**: Most recent IEP and any other pertinent behavioral records

If referred by a **county**: Most current Tx Plan

If referred by a **hospital**: History +Physical (Intake), Discharge Summary

For Internal Use Only

Records requested: yes/no Date: From:

Date Received _____ Date of IE_____

Date completed CAFAS _____ Date of multidisciplinary meeting_____

IOP decision_____ Date of family meeting_____