# **Catalpa Health Intensive Outpatient Program Referral Form**

Fax (920) 882-5495 4635 W College Ave. Appleton, WI 54914

Patient Name DOB:

School

Date of Referral:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family is aware, and in agreement with IOP referral [ ] YES [ ] NO

|  |  |  |
| --- | --- | --- |
| **Symptom** | **Current, Past, Never** | **Description** |
| 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 |  |  |
| Substance Use |  |  |

**Current-within 30 days, past- no symptoms in last 30 days, never occurred**

**Referral information**

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

What is the client’s history of behavioral health treatment services?

**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