Intensive Outpatient/Partial Hospitalization

Referral Screening Form – PeaceHealth Sacred Heart Medical Center Behavioral Health Services

Referrals are reviewed daily. Please fax referral to:(458) 205-6924 or e-mail form to iopphpreferrals@peacehealth.org.

Date/Time of Referral: **Program:** IOP PHP

Patient overview:

Name	
DOB	
Patient insurance (include name and ID)	
Referring Person and contact phone	
Patient's contact phone	
Patient's mental health providers, contact phone	
Medications	

Additional questions:

- Please briefly outline relevant treatment history, presenting problem, and reason for referral:
- Please outline any safety concerns:
- Has patient had thoughts/plan/acts of hurting self during the past week?

**Please note that a referral is not a guarantee of acceptance into the program. Every referred client will be contacted and screened for admission. Please notify patients that they will receive a call and ideally, to have their voicemail boxes setup and able to receive messages in the event they cannot answer. Also note that it is recommended that our participants continue to engage with their current therapist for individual treatment throughout the duration of our program.*

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