ALLEGHENY HEALTH NETWORK
Psychiatry and Behavioral Health Institute
500 Blazier Drive, Suite 400
Wexford, Pa 15090
724-934-2420 (Tell)
724-934-2422 (Fax)

ADULT CBT IOP Referral Form

(Please type your responses)

Referring Clinician: **Phone:** **Fax:**	
Other Treating Clinician: **Phone:** **Fax:**	
Patient Name:	
Patient Phone:	
Patient DOB & Age:	**Patient Address:** **EMAIL:**
Insurance Name:	**Additional Insurance** *(If Any)*
Insurance ID Number:	**Insurance Phone:**
Primary Dx:	**Additional Dx:**
Current Medications:	**Psychiatrist, PA-C, CRNP: Can you continue to see this patient for psychopharmacology during their participation in IOP? If NO, the pt will be offered medication consultation sessions occurring only in context of IOP. We cannot absorb IOP patients upon discharge from our program. We ask that you resume care following discharge from IOP.** ☐ **YES** ☐ **NO**
Reason for referral at this time: (Include acuity factors, please)	

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Current SI/HI/SIB? Yes ☐ No ☐ **Pt has the ability to participate in group psychology** *(include any concerns about reading or writing impairments)*:
Drug and alcohol current/past use: **Rehabilitation or Detox for substance use:**

FAX BACK ALONG WITH ROI, INITIAL EVALUATION DOCUMENT, AND LAST TWO NOTES