RHS CARES for YOUth PHP/IOP REFERRAL FORM

ADDRESS: 1619 CURLEW DR., SUITE 7, AMMON, ID 83406, PHONE: 208-523-5319, FAX: 208-523-5627

The Adolescent Partial Hospitalization Program (PHP) at RHS CARES for YOUth is a short-term (6-8 week depending on participants needs) intensive group therapy program for adolescent's ages 12 to 18* years old (so long as they are enrolled in school).

The program runs Monday – Thursday from 8:00-3pm and Friday from 8:00am to 12pm. **Intake appointments are conducted in person.**

RHS CARES for YOUth adolescent PHP provides intensive group therapy, individual therapy, family therapy, case management, TCC, psychiatric care, medication management, youth peer support, and family support services.

Parents/guardians must be reachable in case of an emergency.

DEMOGRAPHIC INFORMATION			
Name:		Date of Referral:	
DOB:	Age:	Gender:	Pronouns:
Primary Language:		Phone#:	
PARENT/GUARDIAN INFORMATION			
Parent/Guardian Name:		Relationship:	
Address:		City/State/Zip:	
Phone #:		Email:	
Parent/Guardian Name:		Relationship:	
Address:		City/State/Zip:	
Phone #:		Email:	
Guardian's primary language:		Preferred Language:	
Legal Guardian if different than above:			
Phone:		Email:	
INSURANCE INFORMATION			
Primary Insurance:		Policy #:	
Subscriber Name:		Relation/DOB:	
Secondary Insurance:		Policy #:	
Subscriber Name:		Relation/DOB:	

CLINICAL INFORMATION

Presenting Problem(s)/ Stressors (Check all that apply): ☐ Anxiety ☐ Depression ☐ Substance Use ☐ Self-harm ☐ Suicide attempt(s) ☐ Social Environment (friends) ☐ Educational achievement/ behaviors/ attendance ☐ Family issues ☐ Legal Issues ☐ Other (please explain): _____

_____

Precipitants to referral: (family, friends, school stressors? Recent upsetting events? High risk factors? _____

_____

_____

CURRENT MEDICATIONS AND DOSES

Medications:	Dose:

Previous mental health diagnosis:

Previous medical diagnosis:

Any cognitive/intellectual disabilities? ☐ Yes ☐ No If yes, explain: _____	Independent with self-care? ☐ Yes ☐ No If no, explain: _____

Is this a step down from inpatient care? ☐ Yes ☐ No If yes, when was the discharge date? _____

Where is the inpatient facility located? _____

PROVIDER INFORMATION

Therapist ☐ **Yes** ☐ **No**

Name:	Phone Number:
Address:	Email:

Medication Prescriber ☐ **Yes** ☐ **No**

Name:	Phone Number:
Address:	Email:

PCP/ Pediatrician ☐ **Yes** ☐ **No**	
Name:	Phone Number:
Address:	Email:

ADDITIONAL INFORMATION

School Presently Enrolled:

Address:	Grade:
Contact person:	Phone #:

Email address:

REFERRAL INFORMATION

Name of Referring agency/person:

How did you hear about RHS CARES for YOUth?

Contact person:	Phone #:

Email address:

****INTAKE OFFICE USE ONLY****

Information entered to Insync? ☐ Yes ☐ No	Date/Person:
Intake Appointment scheduled ☐ Yes ☐ No	☐ Telehealth ☐ In-Person
Date:	☐ 9am ☐ 10am ☐ 11am ☐ 2pm ☐ 3pm
Reminder calls: ☐ 1st ☐ 2nd ☐ 3rd	Phone number: