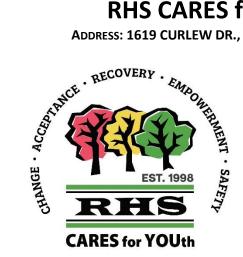
RHS CARES for YOUth PHP/IOP REFERRAL FORM

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/quardians must be reachable in case of an emergency

	T drents/ gad	raidiis iiidst be reachable iii	cuse 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? \square Yes \square 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				
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?	Ţ			
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: \Box 1 st \Box 2 nd \Box 3 rd	Phone number:			