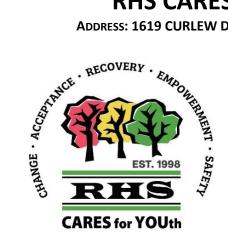
RHS CARES for YOUth PHP/IOP REFERRAL FORM

ADDRESS: 1619 CURLEW DR., SUITE 7, AMMON, ID 83406, PHONE: 208-497-0898, FAX: 208-497-0711



The Adolescent Program (PHP/IOP) at RHS CARES for YOUth are intensive group/individual therapy programs for youth ages 12 to 17 years old.

The PHP program runs Monday – Thursday from 8am-3pm and Friday from 8am-12pm.

IOP is Monday – Thursday from 4pm-6pm during the school year and 1pm-3pm during the summer.

Intake appointments are conducted in person.

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

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

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	DEMOGRAPHI	C INFORMATION	
Name:		Date of Referral:	
DOB:	Age:	Gender:	Pronouns:
Primary Language:		Phone#:	
	PARENT/GUARD	IAN 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 a	bove:		
Phone:		Email:	
	INSURANCE	INFORMATION	
Primary Insurance:		Policy #:	
Subscriber Name:		Relation/DOB:	
Secondary Insurance:		Policy #:	
Subscriber Name:		Relation/DOB:	
	CLINICAL II	NFORMATION	
Presenting Problem(s)/ Stressors	s (<u>Check all that apply</u>):	☐ Anxiety ☐ Depression ☐	Substance Use (if using
substances, please list them in th	e other section) \square Self-h	arm Suicide attempt(s)	Social Environment (friends)
$\ \square$ Educational achievement/ be	haviors/ attendance $\;\Box$ Fa	nmily issues Legal Issues	\square Other (please explain):

Reason for referral: (family, friends, school stressors? Recent upsetting events? High risk factors?) Is the youth on probation? Yes No If yes, who is the probation officer: Probation officer phone number: Any upcoming court dates: Current or Pending Charges: Dose: Previous mental health diagnosis: Previous medical diagnosis: Previous medical diagnosis: Independent with self-care? Yes No If yes, explain: If yes, when was the discharge date? Name and location of the inpatient facility? No If yes, when was the discharge date? Name and location of the inpatient facility? No If yes, when was the discharge date? Name and location of the inpatient facility? No If yes, when was the discharge date? Name and location of the inpatient facility? Name and location of the inpatient facility? No If yes, when was the discharge date? Name and location of the inpatient facility? Name and location of the inpatient facility Name and location of the inpatient facility Name and location of the inpa
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CURRENT MEDICATIONS AND DOSES Medications: Dose: Previous mental health diagnosis: Previous medical diagnosis: Any cognitive/intellectual disabilities?
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Previous medical diagnosis: Any cognitive/intellectual disabilities? Yes No 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?
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If yes, explain: If no, explain: If no, explain: If yes, when was the discharge date?
Is this a step down from inpatient care? Yes No If yes, when was the discharge date?
Name and location of the inpatient facility?
PROVIDER INFORMATION
Therapist Yes No Therapist Name:
Agency: Phone Number:
Address: Email:
Medication Prescriber ☐ Yes ☐ No Prescriber Name:
Agency: Phone Number:
Address: Email:
PCP/ Pediatrician
Agency: Phone Number:
Address: Email:
ADDITIONAL INFORMATION
School Presently Enrolled:
Address: Grade:
Contact person: Phone #:
Email address:
REFERRAL INFORMATION
☐ Internal ☐ External/New ☐ State Hospital ☐ Region 7 ☐ BHC ☐ Other:
Name of Referring agency/person:
Name of Referring agency/person: Contact person: Phone #:
Name of Referring agency/person: Contact person: Email address:
Name of Referring agency/person: Contact person: Email address: **INTAKE OFFICE USE ONLY**
Name of Referring agency/person: Contact person: Email address: **INTAKE OFFICE USE ONLY** Information entered to Insync?
Name of Referring agency/person: Contact person: Email address: **INTAKE OFFICE USE ONLY**