Four Winds SARATOGA

Partial Hospital Program (PHP)/ Intensive Outpatient Program (IOP)

Community Provider Referral Form

Phone: 518-584-3600 x7602

Please include a signed release of information from the patient or parent/guardian

Fax to 518-583-2265 Attn: PHP/IOP Referral

Patient Name: _____ Patient DOB:_____ Age:_____ Parent/Guardian Name: _____ _____ Phone:_____ Address:_____ _____	Patient Insurance:_____ _____ Referent Name & Agency: _____ _____ Referent Contact #:_____ _____

Has the referral been discussed with the patient? **Y / N** Are they in agreement? **Y / N**
Will the patient return to your care after completion of the program? **Y / N**

Please check: All behavioral health and/or community services utilized by the patient:

___Outpatient Therapy ___Outpatient Psychiatry ___Care Management ___CPS/APS or Preventative Services
___ Intensive In-Home Services ___ Specialized School Plan ___Chemical Dependency Treatment
___Other: _____

Reason for Referral

Presenting problems and symptoms/behaviors leading to the referral for the PHP/IOP level of care. (Check all areas of concern & describe below):

___ Recent Inpatient Hospitalization ___ Recent/ Frequent ER visits ___ Recent/Frequent Use of Crisis Services
___ Suicidal Thoughts/Behaviors ___ Self-Injurious Behaviors ___ Other High Risk/ Unsafe Behaviors
___ Substance Use ___ Family Conflict ___ Peer Conflict ___ Aggressive Behavior/s ___ Disordered Eating
___ Trauma Hx ___ Significant Decline in Daily Functioning ___ Out of Home Placement ___Medical Concerns

_____

_____

_____

_____

_____

Please include current diagnosis & medications (if known):

_____

_____

_____

Signature of Referent_____ Date_____