Fair Haven Community Health Care

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Intensive Therapy Program

(ITP) Referral Form

Internal referral should be set via EPIC: Look for "Referral to Fair Haven Behavioral Health ITP (Intensive Therapy Program)" in the Order search.

Referring Organization Contact Information
Name:
Phone Number:
Fax:

PT Name/ MR#:
D.O.B.:
School/Grade:
IEP: Yes/No 504:Yes/No
IEP/504 Type:
Parent/Guardian:
Address:
Phone
Email:
Insurance: (if possible)
Reason for Referral:

Client Diagnosis: DSM-5 Diagnoses with Specifiers & Severity (if referral is from mental health professional)**:**
Psychosocial & Contextual Factors:

Choose Yes or No for the following:	**Yes**	**No**	**If yes, explain here:**
DCF			
School Problems			
Danger to Self			
Danger to Others			
Hallucinations			
Sleeping Problems			
Eating Problems			
Hospitalization			
Other			

Medication (if on any)	**Dosage**	**Fre-quency**	**Prescribed by**	**Date of last Rx**

Have you discussed this referral with the child and his or her legal guardians? YES NO
Will family need medical transportation to ITP appointments? YES NO

How did you hear about us? WEBSITE PREVIOUS BHCARE IOP WORD-OF-MOUTH
OTHER:_____

Please return this form via:
Secure Email a.huang@fhchc.org
Fax: 203-974-0128 – Attn: FHCHC ITP

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