

**Fair Haven Community Health Care**

**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.

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| --- |
| **Referring Organization Contact Information** |
| **Name:** |
| **Phone Number:** |
| **Fax:** |

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

**Will family need medical transportation to ITP appointments?** YESNO

**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) 974-0134 – Attn: FHCHC ITP

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