Referral for Services

Lawrence + Memorial Hospital Intensive Outpatient Program (IOP)

Phone: (860)444-5141 Fax: (860)442-4079

Patient Information:

First name:_____ Last Name:_____

Date of Birth:_____ Age:_____ Social Security #:_____ Gender: M☐F☐Other☐

Address:_____

Primary Phone #:_____ Secondary Phone #:_____

Primary Insurance Carrier:_____ ID:_____

Secondary Insurance Carrier:_____ ID:_____

Is this Workers Comp related? Y☐ N☐ Has Workers Comp approved IOP? Y☐ N☐

Referring Provider Information:

Name:_____ Agency:_____

Phone:_____ Fax:_____ Relationship to Patient:_____

Address:_____

Will patient be returning to this provider after IOP?:_____

Reason for referral and anticipated Outcome(s):_____

_____

_____

_____

Information Regarding Condition:_____

_____

_____

_____

SI/HI: Past☐ Present☐ Psychotic Symptoms: Past☐ Present☐ Hx of IP Admits: Y☐ N☐

Medications:_____

_____

_____

_____

Medical Conditions:_____

Does Patient have a primary care provider?: Y☐ N☐ Name:_____

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Substance Use:

Has your patient used/abused, or are they currently using/abusing any of the following substances? Please include last date of use for each at time of referral, typical amount consumed, and frequency.

Alcohol:_____

Marijuana, Hashish:_____

Opioids (including Heroin, fentanyl, Oxycodone, etc):_____

Cocaine/Crack:_____

Stimulants (Amphetamines, Meth, Adderall, etc.):_____

Club or Designer Drugs (MDMA, ecstasy, molly, GHB, Rohypnol, etc.):_____

Dissociative Drugs (PCP, Angel Dust, Dextromethorphan, etc.):_____

Hallucinogens (LSD, Mescaline, Psilocybin, etc.):_____

Steroids:_____

Inhalants:_____

Additional information regarding patients' substance use: _____

_____

_____

_____

_____

Please fax this form along with a signed ROI, as well as: Initial Evaluation, most recent progress notes, med list, etc. to the IOP at (860)442-4079.