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
IOP is Monday – Thursday from 4pm-5:30pm

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, psychiatric care, medication management, youth peer support, and family support services.

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

DEMOGRAPHIC INFORMATION

Name:		Date of Referral:	
DOB:	Age:	Gender:	Pronouns:
Primary Language:		Phone#:	

PARENT/GUARDIAN 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 above:	
Phone:	Email:

INSURANCE INFORMATION

Primary Insurance:	Policy #:
Subscriber Name:	Relation/DOB:
Secondary Insurance:	Policy #:
Subscriber Name:	Relation/DOB:

CLINICAL INFORMATION

Presenting Problem(s)/ Stressors (*Check all that apply*): ☐ Anxiety ☐ Depression ☐ Substance Use (if using substances, please list them in the other section) ☐ Self-harm ☐ Suicide attempt(s) ☐ Social Environment (friends) ☐ Educational achievement/ behaviors/ attendance ☐ Family issues ☐ Legal Issues ☐ Other (please explain):

_____
_____
_____
_____

Clinical information continued:

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: _____
_____

CURRENT MEDICATIONS AND DOSES

Medications:	Dose:

Previous mental health diagnosis:

Previous medical diagnosis:

Any cognitive/intellectual disabilities? ☐ Yes ☐ No If yes, explain: _____	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? _____
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 ☐ Yes ☐ No	PCP Name:
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:	
Contact person:	Phone #:
Email address:	

****INTAKE OFFICE USE ONLY****

Information entered to Insync? ☐ Yes ☐ No	Person:
Intake Appointment scheduled ☐ Yes ☐ No	Phone number:
Date:	☐ 9am ☐ 10am ☐ 11am ☐ 2pm ☐ 3pm
Reminder calls: ☐ 1st ☐ 2nd ☐ 3rd	Notes:

Please fax the completed form to **208-497-0711 or email to lizl@rhscares.com and whitneyr@rhscares.com**