



**Child & Adolescent Acute
Partial Hospital and Intensive
Outpatient Services
Referral Form**

Preferred Site

☐ Wexford: 11279 Perry Highway, Suite 500, Wexford, PA 15090

☐ Pittsburgh (Southside) 1011 Bingham St. Pittsburgh, PA 15203

Phone: 412-246-6668

Fax: 412-235-5322

Email: Adol_PHP_IOP_Intake@upmc.edu

Please Note: Transportation is the responsibility of the caregiver.

Demographic Information:

DATE OF REFERRAL: _____

Name _____

Birth date: _____ Age: _____ SS# _____ - _____ - _____

Address: _____

Telephone: (_____) _____ (_____) _____
Home Cell

School: _____ Grade: _____ Gifted ES LS Reg. Ed

Parent/Guardian Information:

Name _____ Relationship _____ Transportation: _____

Referral Source:

Name _____ Telephone # _____ Agency: _____

Insurance Information:

Insurance Name: _____

Policy# _____

Group# _____

Insurance Holder Information

Name: _____ **DOB:** _____ **SS#:** _____

Medical Assistance: Yes / No MA # _____

REASON FOR REFERRAL: _____

GOAL FOR ADMISSION: _____

****Please complete all indicators below**

Aggression: ☐ Not Present ☐ Verbal ☐ Physical/Fighting ☐ Use of weapons ☐ Property Destruction

Explain/Other: _____

Substance use/abuse: ☐ Not Present ☐ ETOH ☐ THC ☐ Other

Explain/Other: _____

Suicidality: ☐ Not Present ☐ PDW ☐ Ideation ☐ Plan ☐ Gesture ☐ Attempt

Explain/Other: _____

SIB: ☐ Not Present ☐ Yes ☐ Hx

Explain/Other: _____

Homicidality: ☐ Not Present ☐ Ideation ☐ Plan ☐ Gesture ☐ Attempt

Explain/Other: _____

Psychosis: ☐ Not Present ☐ AH ☐ VH ☐ Delusions ☐ Paranoid Ideation

Explain/Other: _____

Abuse hx: ☐ Not present ☐ Physical ☐ Emotional ☐ Sexual

Reported to CYF? Yes / No

Explain/Other: _____

Mood: ☐ Not Present ☐ Depressed ☐ Irritable ☐ Anhedonia ☐ Labile

Explain/Other: _____

Anxiety: ☐ Not Present ☐ School ☐ Separation ☐ Social ☐ Obsessive-Compulsive

Explain/Other: _____

ADHD: ☐ Not Present ☐ Inattentive ☐ Hyperactive ☐ Fidgety ☐ Impulsive ☐ Distractible

Explain/Other: _____

Conduct: ☐ Not Present ☐ Stealing ☐ Fire Setting ☐ Animal Cruelty ☐ School Truancy ☐ Runaway

Explain/Other: _____

ASD/Cognitive/Learning Functioning: ☐ Not present ☐ Learning D/O ☐ Nonverbal ☐ ASD/Asperger's/High Functioning Autism ☐ ID

Explain/Other: _____ **IQ Score:** _____

CURRENT DIAGNOSTIC IMPRESSION: (List Primary Diagnosis First)

Diagnosis: _____

***Note: exclusionary criteria includes: Primary dx of substance use disorder, eating disorder, conduct disorder, ODD, social phobia; IQ lower than 70; persistent, pervasive physical aggression in multiple settings, mandated treatment, untreated psychosis, lack of interest in group therapy*

MEDICAL: ☐ None ☐ Asthma ☐ Headaches/Migraines ☐ Allergies needing EpiPen ☐ Seizures ☐ Diabetes

Explain/Other: _____

Current Medication(s): _____

CURRENT OUTPATIENT PROVIDERS: _____

***It is the expectation that all patients referred to the program will return to their current treatment providers upon discharge*