

ADULT PHP / IOP REFERRAL FORM

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Partial Hospitalization Program (PHP) is a structured, intensive daytime mental health program that provides therapeutic support, skill building, and psychiatric care while allowing individuals to return home in the evening. Program runs Monday through Friday from 9-2pm.

Intensive Outpatient Program (IOP) is a structured mental health program, that provides therapy and skill-building while individuals continue living at home and maintaining daily responsibilities. Program runs 3-5 days per week, Monday through Friday from 9-12pm.

- **In-person** participants will engage in group activities and meet with a clinician and provider throughout treatment. Patients should anticipate participating in a full day of group sessions on their first initial intake day. PHP runs from 9-2pm from Monday to Friday.
- **Virtual** programming provides individuals with the convenience of receiving essential services in their own homes; these sessions are interactive and take place in real-time with actual professionals, not as pre-recorded webinars. Camera participation is mandatory throughout the program.

PHP/IOP Tracks Available:

- **General Co-ed PHP/IOP:** designed to support both mental health stabilization and substance use recovery.
- **Women’s PHP/IOP:** designed to address needs unique to individuals who identify as female.
- **LGBTQIA+ PHP/IOP (The IRIS Program):** designed to address the nuanced needs unique to the LGBTQ+ community.

THIS REFERRAL IS BEING MADE FOR TREATMENT IN THE FOLLOWING PROGRAM: (please check one)

GENERAL CO-ED TRACK	WOMEN’S TRACK	LGBTQIA+ TRACK
In-Person <input type="checkbox"/> PHP <input type="checkbox"/> IOP	In-Person <input type="checkbox"/> PHP <input type="checkbox"/> IOP	In-Person <input type="checkbox"/> PHP <input type="checkbox"/> IOP
Virtual Telehealth <input type="checkbox"/> PHP <input type="checkbox"/> IOP	Virtual Telehealth <input type="checkbox"/> PHP <input type="checkbox"/> IOP	Virtual Telehealth <input type="checkbox"/> PHP <input type="checkbox"/> IOP

Referral Date: _____

DEMOGRAPHIC INFORMATION		
Preferred Name:	Pronouns:	DOB:
Gender:	Sexual Orientation (optional):	
Primary Language:	Marital Status:	Last 4 #s of SSN:
Address:	City:	Zip:
Phone:	Permission to leave a detailed message on this line: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Email:	Permission to send email communications/resources: <input type="checkbox"/> Yes <input type="checkbox"/> No	
INSURANCE INFORMATION		
Patient’s Legal Name:	Sex (assigned at birth):	
Primary Insurance:	Policy #:	
Subscriber Name:	Relation/DOB:	
Secondary Insurance:	Policy #:	
Subscriber Name:	Relation/DOB:	
CLINICAL INFORMATION		
Presenting Problem(s) (please describe reason for referral, current stressors precipitating factors, etc.):		

FULLER HOSPITAL ADULT PHP / IOP REFERRAL FORM

Current Diagnoses if known (please include DSM-V ICD-10 Code):		
Psychiatric Dx:		
Medical Dx:		
Psychosocial Stressors: <input type="checkbox"/> Primary Support Group <input type="checkbox"/> Social Environment <input type="checkbox"/> Educational <input type="checkbox"/> Occupational <input type="checkbox"/> Housing <input type="checkbox"/> Economic <input type="checkbox"/> Legal <input type="checkbox"/> Access to Health Care <input type="checkbox"/> Other:		
ADDITIONAL INFORMATION		
Is this a step down from inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Discharge Date:
Ever been diagnosed with an eating disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Last active time frame:
Accommodation Needed (including PT-1, medical devices, special diets, etc.):		
Any Cognitive/Intellectual Disabilities?		
Current legal issues: <input type="checkbox"/> None <input type="checkbox"/> Court-Ordered Treatment <input type="checkbox"/> Open Charges:		
Additional important information:		
OUTPATIENT PROVIDER INFORMATION		
Outpatient Therapist: <input type="checkbox"/> Yes- Info below <input type="checkbox"/> NO- Referral Needed <input type="checkbox"/> On Waitlist with:		
Name:	Agency:	Address:
Phone:	Fax:	Email:
Medication Prescriber: <input type="checkbox"/> Yes- Info below <input type="checkbox"/> NO- Referral Needed <input type="checkbox"/> On Waitlist with:		
Name:	Agency:	Address:
Phone:	Fax:	Email:
Primary Care Physician: <input type="checkbox"/> Yes- Info below <input type="checkbox"/> NO- Referral Needed <input type="checkbox"/> On Waitlist with:		
Name:	Agency:	Address:
Phone:	Fax:	Email:
REFERRAL SOURCE INFORMATION		
Name of referring agency/facility:		
Contact Person:		Phone Number:
Email Address:		Fax Number:
How did you hear about Fuller PHP?		
Has patient ever participated in Fuller's PHP before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, dates of attendance:		
INTAKE OFFICE USE ONLY		
Intake Appointment Scheduled <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Telehealth <input type="checkbox"/> In-Person
Date of intake:		<input type="checkbox"/> 9am <input type="checkbox"/> 10am <input type="checkbox"/> 11am <input type="checkbox"/> 12pm <input type="checkbox"/> 1pm
Notes:		