

Trauma-Focused IOP Referral Form

Client name: _____ Client phone number: _____

Client email address: _____

DOB: _____ Gender: M F _____

Referring provider name, facility & mailing address: _____

Phone: _____ Fax: _____ Email: _____

Mental Health History:

Current Diagnosis: _____

Trauma Symptoms: _____

Other Mental Health Symptoms: _____

Types of trauma (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Childhood physical abuse | <input type="checkbox"/> Adult sexual assault |
| <input type="checkbox"/> Childhood sexual abuse | <input type="checkbox"/> Recurring |
| <input type="checkbox"/> Childhood emotional/psychological abuse | <input type="checkbox"/> Single incident |
| <input type="checkbox"/> Childhood neglect | <input type="checkbox"/> Adult physical assault |
| <input type="checkbox"/> Medical trauma | <input type="checkbox"/> Recurring |
| <input type="checkbox"/> Due to ongoing medical condition | <input type="checkbox"/> Single incident |
| <input type="checkbox"/> Due to accident, illness, or injury | <input type="checkbox"/> Kidnapping |
| <input type="checkbox"/> Military trauma | <input type="checkbox"/> Death of a family member |
| <input type="checkbox"/> Workplace trauma | <input type="checkbox"/> Natural disaster |
| <input type="checkbox"/> Racial trauma | <input type="checkbox"/> Community based trauma |
| <input type="checkbox"/> Other: _____ | |

Attachment style/Attachment related concerns: _____

Medical problems and treatment: _____

Prior and current mental health/trauma treatment: _____

Current medications (including dose and frequency): _____

Client Name: _____

Substance use: _____

Risk Assessment (SI, HI, and SIB): _____

Current living situation: _____

Primary support system: _____

Is the client currently in a dangerous environment/situation? Yes No

If yes, please explain: _____

Requirements of IOP Admission:

Is the patient ambulatory? Yes No

Details: _____

Can the patient manage her/his own medications? Yes No

Details: _____

Are there any limitations on physical activities? Yes No

Details: _____

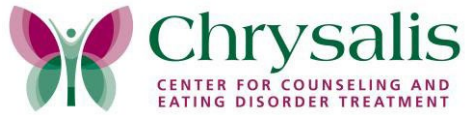
Are there additional assessments needed? Yes No

Details: _____

Are there any medical/psychiatric/medication instructions? Yes No

Details: _____

Allergies: _____



3240 Burnt Mill Drive ▪ Suite 1 ▪ Wilmington, NC 28403 ▪ Tel: 910-790-9500 ▪ Fax: 910-796-8111

Client Name: _____

Primary Insurance Information (please include information on family member whose insurance you are covered by, if applicable):

Insurance Plan Name: _____

Subscriber Number or Member ID Number: _____

Group Number: _____

Employer's Name: _____

Client's Relationship to Policy Holder: _____

Policy Holder's Full Name (Including Middle): _____

Policy Holder's Address, Phone Number, Social Security Number and Birth Date: _____

Secondary Insurance Information (If applicable):

Insurance Plan Name: _____

Subscriber Number or Member ID Number: _____

Group Number: _____

Employer's Name: _____

Client's Relationship to Policy Holder: _____

Policy Holder's Full Name (Including Middle): _____

Policy Holder's Address, Phone Number, Social Security Number and Birth Date: _____

Additional information/comments: _____

Provider Signature: _____

Date: _____

Client Name: _____

INSTRUCTIONS: Below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then select one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

	In the past month how much have you been bothered by the following:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1	Repeated disturbing and unwanted memories of the stressful experience					
2	Repeated, disturbing dreams of the stressful experience?					
3	Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?					
4	Feeling very upset when something reminded you of the stressful experience?					
5	Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?					
6	Avoiding memories, thoughts, or feelings related to the stressful experience?					
7	Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?					
8	Trouble remembering important parts of the stressful experience?					
9	Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?					

	In the past month how much have you been bothered by the following:	Not at all	A little bit	Moderately	Quite a bit	Extremely
10	Blaming yourself or someone else for the stressful experience or what happened after it?					
11	Having strong negative feelings such as fear, horror, anger, guilt, or shame?					
12	Loss of interest in activities that you used to enjoy?					
13	Feeling distant or cut off from other people?					
14	Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?					
15	Irritable behavior, angry outbursts, or acting aggressively?					
16	Taking too many risks or doing things that could cause you harm?					
17	Being "superalert" or watchful or on guard?					
18	Feeling jumpy or easily startled?					
19	Having difficulty concentrating?					
20	Trouble falling or staying asleep?					