Chrysalis
CENTER FOR COUNSELING AND EATING DISORDER TREATMENT

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

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):

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

Attachment style/Attachment related concerns: _____

_____

Medical problems and treatment: _____

_____

Prior and current mental health/trauma treatment: _____

_____

Current medications (including dose and frequency): _____

_____

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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: _____

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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: _____

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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)?					

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	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?					