

Behavioral Health Services Porter Adventist Hospital



Mental Health Intensive Outpatient Program
2465 S. Downing Street, #110
Denver, CO 80210
Intake Phone: 303-778-5774
Intake Fax: 303-778-2436

Mental Health-Intensive Outpatient Program Referral Form

Patient Name: _____ **DOB:** _____

Patient's Phone Number: _____

Diagnostic Impressions

Reason for Referral (Please include pertinent information, listing patient's needs and all significant current symptoms): _____

Danger to Self **Danger to Others** **Psychosis** **Drug Use** **ETOH**

Medical Problems: _____

Medications: Yes No Unknown

Is the client medication compliant? Yes No Unknown

Goals for IOP: _____

Insurance: _____

(We are able to accept Commercial Insurance, Medicare and some Medicaid Policies)

Referring Provider's Name: _____

(Please Print)

Date: _____ **Provider Phone:** _____ **Fax:** _____

Please fax the following to: 303-765-2436

- Referral Form
- Records (i.e. Psychiatric History, Psychosocial Evaluation and/or Discharge Summary) if relevant.

Please ask your patient to call 303-778-5774 to complete a phone screening.