Trusting Konnections

Intensive Outpatient Program (IOP) Referral Intake Form

Client Information

Full Name: _____

Date of Birth: _____

Phone Number: _____

Email Address: _____

Gender Identity: _____

Preferred Pronouns: _____

Address: _____

Emergency Contact Name & Number: _____

Referral Source

Referring Person/Agency Name: _____

Title/Role: _____

Contact Phone: _____

Contact Email: _____

Relationship to Client: _____

Clinical Information

Reason for Referral: _____

Primary Diagnosis: _____

Co-occurring Diagnosis (if applicable): _____

Substance(s) Used: _____

Date of Last Use: _____

Medications (current): _____

History of Psychiatric Hospitalization:

[ ] Yes

[ ] No - If yes, explain

Currently Receiving Therapy or Psychiatry?:

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[ ] Yes

[ ] No - Provider Name/Location

Legal Involvement:

[ ] Yes

[ ] No - Details

Suicidal/Homicidal Ideation:

[ ] Currently

[ ] In Past

[ ] Never

Program Suitability

Client is medically stable:

[ ] Yes

[ ] No

Client is able to commit to 3 days/week:

[ ] Yes

[ ] No

Client has access to transportation:

[ ] Yes

[ ] No

Client has housing stability:

[ ] Yes

[ ] No

Interpreter or accessibility needs?:

[ ] Yes

[ ] No - Language/Needs

Referral Checklist

[ ] Recent clinical summary or assessment

[ ] Medication list

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[ ] Insurance info or funding source

[ ] Release of information (ROI)

Additional Notes

_____

_____

_____

_____

_____

Submission Instructions

Submit completed forms to:

Email: trustingkonnections@gmail.com

Fax: (if available)

Secure upload via website (if applicable)