

Outpatient Information for Inpatient Residential Referrals

Patients Name: _____ Date: _____ DOB: _____ SSN: _____

Psychiatric diagnosis during outpatient treatment (Axis I-IV): _____

Treatment plan problems/needs addressed during outpatient treatment: _____

List all agencies that are involved in the client's care: _____

Date client last attended individual therapy session: _____ Date client and family attended last family therapy session: _____

Date client attended last medication management session: _____ How often is client seen for medication management? _____

Crisis interventions provided within the last 6 months to client/and or family: _____

Frequency of individual therapy from a LMHP: _____ Total # of sessions within last 90 days: _____

Frequency of family therapy sessions from a LMHP: _____ Total # of sessions within last 90 days: _____

Other outpatient services received (frequency & type): _____

Please describe the severe disturbance of affect, behavior, thought process or judgment that cannot be managed safely in an outpatient treatment setting: _____

Sexual Acting Out History: _____

Please list the type(s) and date(s) of serious physically destructive acts committed by the client in the last 30 days: _____

Does the client have legal charges? _____ Is there court involvement (reason/type)? _____

Please list the dates and length of stay of acute hospitalizations during the past year: _____

What must happen/change in an inpatient setting for the client to be successfully returned to the outpatient setting? _____

Therapists Signature: _____ Guardian Name and Contact Number _____