Edelweiss BEHAVIORAL HEALTH

Patient Referral to Adult OCD IOP

Date of request: _____

Demographic Information

Client Name: _____ DOB: _____

Address: _____ City, State, Zip: _____

Phone #: _____ Email: _____

Primary/Secondary Insurance (if known): _____

Has the client agreed to participate in all requirements of the program? ___Yes ___No

Clinician/Referral Information

Referring Provider Name/Clinic: _____

Phone #: _____ Email: _____ Fax #: _____

Is client currently engaged in psychotherapy with you? ____Yes ____No

Date of last visit: _____ Frequency of visits: _____

Please list current diagnoses:

Current medications:

Has client engaged in ERP or any other evidence-based treatment for OCD in the past? If so, please list:

Please include any other pertinent information:

Thank you for your referral.

We will contact your client to schedule an intake appointment and/or start date if they meet initial criteria for the program.