Group Health Cooperative of South Central Wisconsin

Foundations IOP External Referral form

GHC-SCW, 8202 Excelsior Dr, Madison, WI 53717

Thank you for referring your patient to GHC-SCW Foundations IOP. Our program is located at our Sauk Trails location. Hours are Monday through Friday 9 a.m.-12 p.m. and 1:30 p.m.-4:30 p.m. Our program treats adults with general behavioral health concerns. Program content includes psychiatric assessment, CBT and DBT group therapies and individual therapy.

If you have questions, please contact us at: (608) 662-5071 **Date of Referral:_____**

Demographic Information

Name of Patient:		Pronouns:	
Address:			
Best Contact #:		DOB:	

Insurance Information

Insurance Co:			
ID#:		Group #:	
Subscriber Name:		DOB:	
# To Verify Benefits:			
GHC Employee or Family of Employee:			

Referral Source

Referring Provider Name:	Credentials:		
Agency::			
Phone::		Email (required):	
Length of Treatment Relationship:		Date of most recent visit:	

Clinical Information

Provide a brief description of the patient's current symptoms, functional impairment and reason why needs are best met at IOP level of care:

Provide a description of recent safety concerns including non-suicidal self-injurious behaviors, suicide behaviors or attempts, risk taking behaviors, inability to care for self and aggression or threats to others:

Clinical Goals

Primary Goal:	
Secondary Goal:	

Current Behavioral Health Diagnoses

1:	
2:	
3:	
4:	
5:	

Has the patient agreed to participate in GHC Foundations IOP if accepted?
Is the patient likely to be able to maintain safety with IOP level of support?
Is substance use an active concern?
Is an eating disorder an active concern?
What treatment alternatives to IOP have been or are being considered?
Previous Mental Health Treatment Programs (include hospitalizations, PHP/IOP, outpatient and substance use treatments)
Substance Use (current and history of problematic use)
Alcohol:
Tobacco:
Drugs:
Caffeine:
Current Medication (name, dose and frequency)
Medication allergies and adverse reactions:
Is the patient compliant with medications? If not, what are identified barriers?
What medication adjustments or changes are deemed necessary?
Past Medical History
Any other pertinent social or trauma information
Current Outpatient Treatment

Psychiatrist:		Dietician:	
Therapist:		Other:	
Primary Care:	Anticipated prescriber at discharge:		

Comments/Other Relevant Information