UMPQUA HEALTH ALLIANCE

INTENSIVE IN HOME BEHAVIORAL HEALTH TREATMENT (IIBHT) REFERRAL FORM

Is the Family aware of the referral : ☐ Yes ☐ No Date of Referral:

Referring Provider : Email :

Phone Number : Communication Preference : ☐ Phone ☐ Text ☐ Email

YOUTH INFORMATION

Youth Legal Name : Pronouns :

Preferred Name : Date Of Birth :

Address : OHP Number :

City : State: Zip Code :

Legal Guardian : Email :

Phone Number : Communication Preference : ☐ Phone ☐ Text ☐ Email

Current Primary Care Physician :

Medical Conditions/Allergies :

Current Therapist : Agency :

Current Diagnosis :

YOUTH ELIGIBLE FOR IIBHT ARE:

☐ Between the ages of 0 - 20 ☐ More than one diagnosed behavioral health condition

☐ Challenges impacting multiple areas of their life: ☐ School ☐ Home ☐ Community

☐ At risk of out-of-home placement, treatment, or hospitalization

☐ At risk of injury to self or others

Are they returning to the community from out-of-home placement or treatment program?

☐ Yes ☐ No If yes, please attach the discharge/transition plan to this referral

Has the youth previously received any of the following services:

☐ Outpatient Mental Health Therapy ☐ Psychiatric Services or Medication Management

☐ Skills Training ☐ Wraparound Care Coordination ☐ Case Management

☐ Comprehensive well-check by Primary Care Physician (PCP)

☐ Behavior Support Services through a School District (IEP or 504 Plan)

☐ Psychological assessment from any reason, including developmental disorders

Additional Comments :

Please email this completed form to IIBHTReferrals@Adaptoregon.org