Internal Use Only
Received by:
Date received:
Date contacted referral source:

Intensive Outpatient Program Referral Form

1. Referral source/Facility (name, contact information):
   _____
   Phone Number: _____
2. Client's name, age, & date of birth:
   _____
3. Client's contact information (address, phone number):
   _____
4. Client's insurance: _____
5. Is the client currently receiving mental health or substance abuse services? If so, what? (Outpatient therapy, group therapy, opioid treatment): _____
6. Known medications/diagnoses: _____
   _____
   _____
7. Reason for Referral:
   _____
   _____
   _____

Please fax this form to (910) 341-5779, Attention: Rakhee Patel, SAIOP Supervisor. Please label fax as URGENT OR email this form to rpatel@coastalhorizons.org Subject: IOP Referral.