

**ADULT THOUGHT DISORDERS**

**INTENSIVE OUTPATIENT PROGRAM (IOP)**

**REFERRAL FORM**

**PLEASE FAX to 310-206-1157**

Date/Time of Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #:\_\_\_\_\_\_\_\_\_\_\_

**Diagnosis:­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Psychosocial Stressors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* Non-UCLA Outpatient
* Please attach updated clinical summary with reason for referral and patient’s contact information*.*
* UCLA Outpatient
  + Please provide reason for referral and MRN.

**APHP Criteria Met:**

* Availability to Attend Program 3 Days Per Week.
* Demonstrated Ability to Participate in Group Treatment
* Diagnosis of a Primary Psychotic Disorder (Schizophrenia or Schizoaffective)
* Motivated for Treatment
* Ability to Concentrate
* Stable Housing

**If Applicable:**

* No Active Substance Use that Interferes with Treatment

Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Resident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please Print) (Please Print)

Pager #: \_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_ Pager #: \_\_\_\_\_\_\_\_\_\_

Referring Social Worker **or** other Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please Print)

Pager #: \_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_

Requested Start Date: \_\_\_\_\_\_\_\_

**Please call APHP if you have any questions at (310) 825-7469**