Columbus Behavioral Center
for Children and Adolescents

Intensive Outpatient Program (IOP) for Adolescents
Professional Referral Form

REFERRAL SOURCE INFORMATION

Name: _____

Agency: _____

Phone Number: _____

Email: _____

ROI Obtained? ( ) yes ( ) no

PATIENT INFORMATION

Name: _____

Pronouns/Preferred Name: _____

Date of Birth: _____

School: _____

Diagnoses/Concerns:_____

_____

_____

_____

Type of Insurance/Policy Number: _____

CAREGIVER INFORMATON

Name: _____

Relationship to Youth: _____

Phone Number(s): _____

Email Address: _____

Please send completed referral form to IOP Program Coordinator ColumbusIOPIntake@uhsinc.com

Columbus Behavioral Center IOP
4105 Vickers Dr.
Columbus, IN 47203
(812) 565-9323