IOPREFERRAL

Institute of Psychiatry

STAR INTAKE REFERRAL INFORMATION

Form Origination Date 1/06
Version 6 Version Date 7/12

Patient Name ______________________
MRN ______________________
PATIENT IDENTIFICATION LABEL

All areas of this form must be completed to facilitate your referral. It is very important to include legal guardian and insurance information.

Referral Date: ____________________

Patient Name: ____________________ D.O.B.: __________ Age: ______ Race: ______ Sex: ______

Address / City / State / Zip: ______________________________

County of Residence: ____________________ School Grade: ________ Patient's SSN: ______________

School student attends: ______________________________

Legal Guardian Contact Information

Contact Name: ______________________________ Relationship: ______________

Address / City / State / Zip: ______________________________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Lead Agency: ______________________________ Phone: ______________

Referrer Information

Name: ______________________________ Relationship: ______________

Referrer Agency / School: ______________________________ County: ______________

Address / City / State / Zip: ______________________________

Phone: ______________ Pager: ______________ Fax: ______________

Current Physician: ______________________________ Phone: ______________

Diagnosis: ______________________________

Plan for Transport to the Program: ☐ Family vehicle ☐ Public school bus ☐ Other: ______________

Insurance Information

Insurance I	**Insurance II**
Insurance Company: ______________	Insurance Company: ______________
Policy Holder: ______________	Policy Holder: ______________
Policy Number: ______________	Policy Number: ______________
Employer: ______________	Employer: ______________
Benefits Phone: ______________	Benefits Phone: ______________
Guarantor Name: ______________	Guarantor Name: ______________
Guarantor SSN: ______________	Guarantor SSN: ______________

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Clinical Information

Provide brief history and describe behaviors disrupting current school and / or home placement.

____
____
____
____
____
____
____
____
____

Self-harm behavior: ☐ Yes ☐ No History of violence: ☐ Yes ☐ No Estimated Ht.: _____ cm Estimated Wt.: ____ kg

Any current DSS / Legal involvement: ________________________________

Medication History		
Past Medications	**Dose**	**Frequency**
Current Medications	**Dose**	**Frequency**

Past hospitalizations, placements, and other interventions: ________________________________
____

Outpatient Therapy

Present Therapist: ____________________ Phone: ____________ Pager: ____________
Present Psychiatrist: ____________________ Phone: ____________ Pager: ____________
Acute Medical Conditions: ____________________ Chronic Medical Conditions: ____________________

Goals / Objectives for Children's Day Treatment

____
____

Fax or Email completed form to:

STAR ages 6-17
1001-B Michigan Avenue
North Charleston, SC
29418 843.876.2670
843.876.2696 Fax

Or

Email completed form to:

olsens@musc.edu
or
daffronr@musc.edu