Provider Referral Form for UCSF OCD IOP

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship with Patient: Therapist/Psychiatrist

Please mark yes or no for the following regarding your referral:

* Patient has severe OCD. Yes/No
* Patient is motivated for change. Yes/No
* Patient is able to attend treatment in-person at UCSF. Yes/No
* Patient has active suicidal ideation. Yes/No
* Patient has a primary psychotic disorder. Yes/No
* Patient engages in ongoing substance use. Yes/No

Please complete these questions to help us learn more about your referral.

1. What are the patient’s diagnoses?
2. What are the patient’s most prominent OCD symptoms?
3. Why is the patient being referred to the IOP? What level of care do they need? Please elaborate.
4. What is the patient’s treatment history for OCD (medications, therapy, IOP, TMS, research, etc)?
5. What medications are currently prescribed for patient? How is their medication compliance?
6. What substances does the patient currently use? Any significant substance use history?
7. What safety issues has patient experienced in the past and in the present?
8. Are there other individuals involved in patient’s care? If yes, please list below.