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Integrated Health Care

Intensive In-Home Behavioral Health Treatment (IIBHT) Referral Form

The IIBHT program is the highest level of outpatient care available. It is designed to be a transition placement for youth entering or nearing the need to enter psychiatric residential treatment services, sub-acute treatment, in-patient treatment, or behavioral residential services. Additionally, it is a transition placement of care for youth exiting any of the above listed levels of care. Youth referred to this program need to meet certain criteria related to acuity. It is imperative that we keep youth in the least restrictive level of care possible. Please consider this before submitting the IIBHT referral. Other services/processes that could be considered before IIBHT, include:

- ☐ Outpatient mental health services (individual and family therapy)
- ☐ Skills training in addition to therapy
- ☐ Behavioral Support Services through a school district
- ☐ Wraparound Coordination/Case Management
- ☐ Comprehensive well-check by PCP
- ☐ CDRC referral for full diagnostic assessment including developmental disorders

If the above listed services/process have been exhausted, or if the youth is transitioning to or from an in-patient level of care, please consider making an IIBHT referral.
It is a service delivery program which includes:

- ☐ A minimum of four hours of weekly service, including:
  - Individual/Family/Group Therapy
  - Psychiatric Services
  - Skills training
  - Peer Support
  - Wraparound Care
  - Intensive Care Coordination
  - 24/7 Crisis Support
  - Case Management
- ☐ 30-day treatment team meetings
- ☐ Case Coordination with Umpqua Health Alliance (UHA)
- ☐ Thorough Transition and Discharge Planning

P.O. Box 1121, Roseburg, OR 97470
Fax 541-440-3532 Attn: IIBHT | IIBHT@adaptoregon.org
Rev. 12.20.2022

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Client Name and Pronouns:	DOB:	Client Address:	Date of Referral:
Race:	Ethnicity:	Primary Language Spoken:	School:
Legal Guardian Name:	Client/Guardian Phone Number:	Please circle one: Biological household Foster Care Adopted Other:	Current PCP/PMHNP:
Medical Conditions (if applicable):	Current Adapt Client. Please circle one: Yes No	Other services involved:	Current Therapist:
Current Diagnosis:	Referring Provider contact info:	Family informed of this referral: ☐ Yes ☐ No	Insurance Coverage: Please circle one: OHP Private Insurance Other:_____

Please select all that apply:	
☐ Multiple behavioral health diagnoses	☐ Risk of losing school placement
☐ Impact on multiple life domains	☐ Individual Education Plan(IEP) (please attach)
☐ Significant safety concern: (please explain below)	☐ PRTS/BRS placement in last 6 months
☐ Suicide Risk: (Attach C-SSRS)	☐ Transitioning back to community from PRTS/Sub-acute/in-patient/BRS level of care
☐ Risk of losing home placement	☐ Other: (please explain below)

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Comments:

Please email this form completed to IIBHTReferrals@Adaptoregon.org

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