adapt
Integrated Health Care

Intensive Child/Adolescent Outpatient Behavioral Health Services 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, subacute 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 youth remain at 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)
- ☐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 two hours of weekly service, including

- ☐Individual/Family/Group Therapy
- ☐Psychiatric Service
- ☐Skills Training
- ☐Peer Support
- ☐Wraparound Care
- ☐Intensive Care Coordination
- ☐24/7 Mobile Crisis Support
- ☐Case Management
- ☐90-day treatment team meetings
- ☐Case coordination with Advanced Health or Allcare Health
- ☐Thorough Transition and Discharge Planning

Brookings
615 5th St
P.O Box 597
Brookings, OR 97415

Gold Beach
29845 Airport Way
P.O Box 750
Gold Beach, OR 97444

Port Orford
1403 Oregon St
Port Orford, OR 97456

adapt
Integrated Health Care

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

Client Name:	DOB:	Date of Referral:	Referring Provider/ Contact Info:
Legal Guardian Name(s)	Client/Guardian Phone Number(s):	Client Address:	Current PCP/PMHNP:
Current Therapist:	Current Diagnosis:	Medical Conditions (if applicable):	Medicaid Number:

Please select all that apply:	
☐ Multiple behavioral health diagnoses	☐ Risk of losing school placement School attended: _____
☐ Impact on multiple life domains	☐ Individual Education plan IEP: (please attach)
☐ Significant safety concern (please explain in Comments)	☐ PRTS/BRS placement in the 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)
Comments:	

Please email this form completed to: IIBHTCurryReferrals@adaptoregon.org or Fax to: 541-440-3537 marked attention: IIBHT Referral Department