



IOP Referral Form

Referent Info:

TX Program Probation County Worker Therapist Self Other: _____
Name: _____ Agency: _____
Phone: _____ Fax: _____ Email: _____

Client Demographics:

Name: _____ DOB: _____ Gender: _____
Funding: _____ Address: _____
Phone: _____ Email: _____

Reason for referral: _____

Substance Use:

Primary Substance: _____ Date of Last Use: _____
Any withdrawal symptoms or concerns? _____
Date of most recent SUD Assessment: _____
Assessment sent to APS? Y/N

Mental Health:

Diagnoses: _____
Current Symptoms or Concerns? _____
Are they currently receiving MH services? Y/N
Name/Agency of Provider(s): _____

Legal Involvement:

Is the client currently involved with the legal system? Yes / No
Probation Agent: _____ County of Probation: _____
Agent Phone: _____ Fax: _____ Email: _____
Does the client have any history of sexual offenses or violent crimes? Y / N
If yes, please describe _____

Risk Factors

Any immediate safety concerns (suicidal ideation, harm to others, homelessness)?

Other relevant information: _____

Referent Preferred Contact Method: _____
Best Time to Contact: _____