STR Referral Form
Residential/Community Based Follow-Up Services/IOP

Date: _____ Employee taking referral: _____

Name of the Referring Person: _____

Referring Agency: _____ PH# _____

Client Name: _____ Client DOB: _____

Phone #: _____ Cell # _____

Parent/Guardian's Name: _____

Primary Insurance: _____

Pediatric Group/Clinic: _____

Current Medications: _____

Reason for Placement: ◯ CHINS- ◯ Truancy or ◯ Ungovernable

Or ◯ Delinquent- Reason _____

Previous Placements: _____

Juvenile Case number: _____

Status: Accepted / Rejected/ Follow-up/ Admission Date/Time:

ADDITIONAL COMMENTS: _____

_____

Residential _____ CB (STEPS) _____ IOP (Substance Abuse) _____

Desired length of stay: 2 Weeks◯ 30 Days◯ 90 Days◯

Other _____

- **Original in Student's Packet**
- **Copy to Dr. Faulk**

Revised 4/3/14