Allegheny Health Network

Psychiatry and Behavioral Health Institute
500 Blazier Drive, Suite 400
Wexford, PA 15090
Ph: 724.934.2420; Fax: 724.934.2422

Allegheny Health Network and PBHI Blazier Clinic Health Services

PBHI Blazier Clinic Adolescent CBT-DBT Intensive Outpatient Program

Referral Form

500 Blazier Drive, Suite 400
Wexford, PA 15090
☎ Office 724-934-2484
☎ Fax 724-934-2422
Email: Sirena.Claxon@ahn.org

Referring Clinician: Phone: Fax:	
Other Treating Clinician: Phone: Fax:	
Patient Name:	
Patient Phone:	
Patient DOB:	**Patient Address:**
Insurance Name: Medical Assistance: Yes/No	**Additional Insurance (If Any)**
Insurance ID #: **Medical Assistance #:**	**Insurance Phone:**
Axis I:	
Current Medications:	**Past Medications:**
Reason for referral at this time: (Please include acuity factors):	
Current SI? Yes/No **Hx of SI?** Yes/No **Recent suicide attempt?** Yes/No **HX of suicide attempt?** Yes/No **Current SIB?** Yes/No **HX SIB?** Yes/No **Current HI?** Yes/No **Hx HI?** Yes/No **Contracting for safety?** Yes/No	***Please describe presenting safety concerns (SI, PDW, HI, SIB, etc) and frequency**:*

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Supports/ Resides with: Name: Name:	Relationship: Relationship:	Number: Number:
School:	**Grade:**	**IEP/504 Plan:** Yes/No
Psychosis: Yes/No (If yes, please indicate AH, VH, delusions)		
Abuse history: Yes/No (*If yes, please indicate physical, sexual, verbal, mental)*		**Reported:** Yes/No
Aggressive behaviors: *Yes/ No (If yes, please describe.)*		
Conduct behaviors: *Yes/ No (If yes, please describe.)*		
Drug and alcohol current/past use: *Yes/ No (If yes, please indicate substance and frequency of use.)*		

EMAIL/FAX BACK ALONG WITH DEMOGRAPHICS SHEET, INITIAL EVALUATION DOCUMENT AND LAST TWO NOTES