PRINT BLANK FORM | PRINT COMPLETED FORM AND RESET | RESET FORM

MUSC Health
INSTITUTE OF PSYCHIATRY

IOPREFERRAL

Institute of Psychiatry

STAR INTAKE REFERRAL INFORMATION

Form Origination Date 1/06
Version 6 Version Date 7/12

Patient Name _____
MRN _____
PATIENT IDENTIFICATION LABEL

All areas of this form must be completed to facilitate your referral. It is very important to include legal guardian and insurance information.

Referral Date: _____

Patient Name: _____ D.O.B.: _____ Age: _____ Race: _____ Sex: _____

Address / City / State / Zip: _____

County of Residence: _____ School Grade: _____ Patient's SSN: _____

School student attends: _____

Legal Guardian Contact Information

Contact Name: _____ Relationship: _____

Address / City / State / Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Lead Agency: _____ Phone: _____

Referrer Information

Name: _____ Relationship: _____

Referrer Agency / School: _____ County: _____

Address / City / State / Zip: _____

Phone: _____ Pager: _____ Fax: _____

Current Physician: _____ Phone: _____

Diagnosis: _____

Plan for Transport to the Program: ☐ Family vehicle ☐ Public school bus ☐ Other: _____

Insurance Information

Insurance I

Insurance Company: _____
Policy Holder: _____
Policy Number: _____
Employer: _____
Benefits Phone: _____
Guarantor Name: _____
Guarantor SSN: _____

Insurance II

Insurance Company: _____
Policy Holder: _____
Policy Number: _____
Employer: _____
Benefits Phone: _____
Guarantor Name: _____
Guarantor SSN: _____

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Clinical Information

Provide brief history and describe behaviors disrupting current school and / or home placement.

Self-harm behavior: ☐ Yes ☐ No History of violence: ☐ Yes ☐ No Estimated Ht.: ____ cm Estimated Wt.: ____ kg

Any current DSS / Legal involvement: _____

Medication History		
Past Medications	**Dose**	**Frequency**
Current Medications	**Dose**	**Frequency**

Past hospitalizations, placements, and other interventions: _____

Outpatient Therapy

Present Therapist: _____ Phone: _____ Pager: _____

Present Psychiatrist: _____ Phone: _____ Pager: _____

Acute Medical Conditions: _____ Chronic Medical Conditions: _____

Goals / Objectives for Children's Day Treatment

Fax completed form to:

STAR ages 6-17
1001-B Michigan Avenue
North Charleston, SC 29418
843.876-2670
843.876.2696 Fax

Or

Email completed form to:

olsens@musc.edu
or
daffronr@musc.edu

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