Butler Hospital
OCD and Anxiety Disorder
Intensive Outpatient Program (IOP)
Intake Phone: 1 (844) 401-0111 Fax: (401) 680-4122

The OCD and Anxiety Disorders IOP is a behavioral therapy program focused mainly on Exposure and Response Prevention (ERP) or Prolonged Exposure techniques. The program runs **Monday through Thursday from 2-5 p.m**. Length of stay is determined by the nature of the patient's symptoms, their progress, and engagement in the program. The average length of stay is four to seven weeks.

During the initial phase of the program, we conduct a comprehensive evaluation and develop an individualized treatment plan. The treatment team consists of a psychologist, psychiatrist, and behavioral therapists. Patients coming into our program must be able to attend the program each day and participate in individual and group therapy sessions. Groups are small (six to eight patients) and are focused on assisting people overcome their fears (including fears of being in a group).

In order to determine whether patients are a good fit for our program, we ask you to provide the information detailed below and the treatment provider form. You may attach a medication list, D/C summary, and any other pertinent information, but please make sure that all the information requested is included.

Our goal is to provide patients with skills to improve their functioning and be able to continue to make progress in outpatient care. Therefore, we usually require that a patient has a treatment provider that can continue working with him/her after discharge. In some cases (e.g. there are safety concerns or patient needs daily monitoring of medications), patients may need an alternative level of care (inpatient, partial hospital, or outpatient) before attending our program. We look forward to working with you and thank you for referring your patient.

Request for Services:(please check) OCD_____ Anxiety_____

Demographic Information:

Patient Name:_____ DOB:_____

Address:_____ City, State, Zip Code:_____

Phone #:_____

How did you hear about us? (please circle): Brochure Radio / TV Colleague Family / Friend

Clinical Information:

Referral Source Name:_____ Phone:_____

Referred from (where will patient be coming from? (please circle)

Inpatient Partial Hospital Outpatient PCP Emergency Room Residential

Insurance Information (If known):

Primary Insurance:_____

Policy #:_____Policy Holder: _____

Secondary Insurance:_____

Policy #:_____Policy Holder:_____

Patient Name: _____

Treatment Provider Referral Form

1. Please provide a psychosocial history of patient, description of current symptoms (OCD, panic disorder, social anxiety, phobias) and current level of impairment. You may attach a recent intake or progress note if it includes all the information.

2. Does the patient have any co-morbid psychiatric conditions that may interfere with treatment? What is the current status of these conditions?

3. Please check if any of the following symptoms are current (occurred in past month) and describe symptoms below.

_____Suicidal/Homicidal intent or behaviors_____

_____Substance abuse (other than nicotine)_____

_____Violent/aggressive behaviors _____

_____Self-injurious or impulsive behaviors _____

_____Legal problems _____

4. Describe patient's current support system and living situation.

Psychiatric History

5. Is there any past substance abuse history, including any treatment for substance abuse?

6. Is there a history of acting violently or demonstrating aggressive behavior?

Treatment: Current and Past

7. Please attach a current medication list and information about the patient's medication history.

8. Is patient currently attending psychotherapy? ____Yes ____No

Has patient tried ERP or prolonged Exposure? ___Yes, current ____Yes, past ___No

Please include any relevant information regarding patient's experience with cognitive-behavioral therapy.

Thank you for your referral. We will contact the patient and give them an appointment and/or start date if they meet initial criteria for the program.