Butler Hospital

Patient Application Form

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 3-6pm**. 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 4 to 7 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 (6-8 patients) and are focused on assisting people overcome their fears (including fears of being in a group).

In order to determine whether this program is a good fit, we ask you to:

1) complete this application packet and mail it to us at:

OCD and Anxiety Disorders IOP

Butler Hospital

345 Blackstone Boulevard

Providence, RI 02906

2) contact your mental health treatment provider (i.e. your therapist or psychiatrist) and ask them to submit the Provider Referral Form

3) call your health insurance company and inquire about your *intensive outpatient program* benefits.

Once we receive your application and the referral form from your provider, we will call you to schedule an appointment for an evaluation. Please note that our program usually has a waitlist of 4-8 weeks. If you have any questions about the application or the program, please contact us at (401) 455-6564. Our hours are Monday through Thursday 2-6pm.

OCD and Anxiety Disorders IOP
Patient Information Form

Patient Information

Today's Date: _____

Last Name: _____ First Name: _____M.I.: _____

Date of Birth: _____ Age: _____ Sex: ____M ____F

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work/Cell: _____

Other Phone (specify) : _____

Which phone number do you prefer to be contacted at? _____

Occupation: _____Are you currently working? _____Yes ____No

Emergency Contact Person: (Spouse if Married/Parent if Minor)

Name: _____ Relationship to Patient: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work/Cell: _____

Health Insurance Information

Primary Insurance Type :_____

Policy #: _____ Policy Holder: _____

Secondary Insurance Type :_____

Policy #: _____ Policy Holder: _____

I authorize Butler Hospital staff to speak with my insurance company in service of my application to the program. _____Yes _____No

Patient's Signature: _____ Date: _____

Current Treatment Providers (please include medication providers, therapist, etc.)

Primary Care Physician (PCP):

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____

If needed, may we contact this clinician to coordinate your treatment? _____ Yes _____ No

Psychiatrist/Medication Provider:

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____

If needed, may we contact this clinician to coordinate your treatment? _____ Yes _____ No

Therapist:

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____

If needed, may we contact this clinician to coordinate your treatment? _____ Yes _____ No

Past Medical History

Medical Illnesses

Do you now have or have you ever had any medical illnesses? _____Yes _____No

If yes, please list:

_____

_____

_____

Hospitalizations:

Have you ever been hospitalized for psychiatric reasons? _____Yes _____No

If yes, please list the hospital, dates of your stay, and diagnosis.

_____

_____

_____

Outpatient Psychiatric Treatment

Have you been in therapy for a psychiatric condition? _____Yes _____No

If yes, please list the outpatient therapist name, type of therapy (e.g. CBT, behavioral, supportive) and dates of treatment.

Therapist: _____

Therapy Type: _____ Dates of treatment_____

Therapist: _____

Therapy Type: _____ Dates of treatment_____

Current Medication History

What medications are you taking? (Include medical and psychotropic medications, as well as dosages for all)

Medication: _____ Dose: _____ Start date: _____

Medication: _____ Dose: _____ Start date: _____

Medication: _____ Dose: _____ Start date: _____

Medication: _____ Dose: _____ Start date: _____

Medication: _____ Dose: _____ Start date: _____

Medication: _____ Dose: _____ Start date: _____

Past Medication History

Have you taken any of the following medications? If yes, provide maximum dose and time on that dose.

Medication	Took med? (Yes/No)	Maximum Dose?	Time on Max. Dose?	Good Effects	Bad Effects
Anafranil (clomipramine)					
Luvox (fluvoxamine)					
Prozac (fluoxetine)					
Zoloft (sertraline)					
Paxil (paroxetine)					
Celexa (citalopram)					
Effexor (venlafaxine)					
Zyprexa (olanzapine)					
Risperdal (risperidone)					
Haldol (haloperidol)					
Klonopin (clonazepam)					
Xanax (alprazolam)					
Ativan (lorazepam)					

Symptoms

Please describe the types of symptoms you are seeking treatment for. Please describe how they interfere with your daily activities or if there are specific activities places you avoid to your symptoms.

_____

_____

_____

_____

_____

History of Symptoms (refers to OCD or Anxiety Symptoms)

1. At what age did you notice minor (subclinical) symptoms (i.e. symptoms that did not significantly interfere with your normal day-to-day routine or cause you great distress) _____ (age, approximate ok)

   a. Describe the symptoms you noticed at that time.

   _____

2. At what age did your symptoms cause you significant discomfort/distress?

   _____

   _____

3. When did your symptoms begin to interfere with your activities or change your normal routine (e.g. school, work, family life, social activities, sports, etc.)? _____ (age)

   a. How did they interfere? _____

4. How rapid was the onset of your symptoms? That is how long did it take to get to a level where they bothered you a lot or interfered with your day-to-day life?

____Gradual (greater than or equal to 3 months)

____ Intermediate (greater than 1 month and less than 3 months)

____ Sudden (less than or equal to 1 month)

5. When did you first seek treatment for these symptoms? _____

6. Do you have any other psychiatric conditions (now or in the past) such as:

(if yes, indicate whether current or in the past)

_____Depression_____

_____Post-traumatic Stress Disorder_____

_____Bipolar Disorder_____

_____Psychotic Disorder _____

_____Eating Disorder _____

_____Substance Abuse _____

_____Self-injurious behaviors (i.e. cutting, burning) _____