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 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 wait list of four to eight 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 2-5 p.m.*
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: ____________

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.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Took med? (Yes/No)</th>
<th>Maximum Dose?</th>
<th>Time on Max. Dose?</th>
<th>Good Effects</th>
<th>Bad Effects</th>
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<tbody>
<tr>
<td>Anafranil (clomipramine)</td>
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<td>Luvox (fluvoxamine)</td>
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<td>Prozac (fluoxetine)</td>
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<td>Zoloft (sertraline)</td>
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<td>Paxil (paroxetine)</td>
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<td>Celexa (citalopram)</td>
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<td>Effexor (venlafaxine)</td>
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<td>Zyprexa (olanzapine)</td>
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<td>Xanax (alprazolam)</td>
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<td>Ativan (lorazepam)</td>
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</table>
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 three months)

___ Intermediate (greater than one month and less than three months)

___ Sudden (less than or equal to one 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) ________________________________