Main Phone: 617-469-0300
Fax: 857-277-5923

BOURNEWOOD
HEALTH SYSTEMS

Adult Partial Hospitalization Program (PHP) Referral

Date of Referral: _____ Requested Start Date: _____

Program: ☐ Co-Occurring ☐Mental Health ☐ Kaleidoscope (Co-Occurring LGBTQIA+) ☐ DBT-Informed

Referral Name/Agency: _____

Referral Phone: _____ Referral Email: _____

Patient Name: _____ DOB: _____ Gender: _____

Preferred Pronouns: _____ Primary Language _____

Phone: _____Email: _____

Address: _____

Parent/Guardian: _____ Guardian Phone: _____

Primary Insurance: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

Reason for referral: _____

_____

_____

Describe relevant psychiatric & substance use history: _____

_____

_____

History of psychiatric hospitalization, CBAT, PHP, IOP, or outpatient therapy: _____

_____

Current DSM-5-TR/ICD-10 Diagnoses: _____

All current medication names & doses (psychiatric & medical): _____

_____

Describe current living situation: _____

Describe the patient's ability and willingness to participate in groups/treatment: _____

Is patient on a long-acting injectable antipsychotic? _____ Medication & Next Injection Due:_____

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FOR CO-OCCURRING REFERRALS

Patient's substance(s) of choice:_____

Amount/frequency of use: _____ Date of last use: _____

SAFETY

Elopement: ☐ No ☐ Yes: _____

Suicidal ideation: ☐ No ☐ Yes: _____

Suicide attempts: ☐ No ☐ Yes: _____

Self-harm: ☐ No ☐ Yes: _____

Aggression/Violence: ☐ No ☐ Yes: _____

Legal problems: ☐ No ☐ Yes: _____

Eating disorder: ☐ No ☐ Yes: _____

Recent restraint (in past week): ☐ No ☐ Yes: _____

REFERRAL INFORMATION

Call 617-469-0300 for more information. Submit completed referral form via fax to refer to preferred program location:

Brookline Co-Occurring Partial Hospital Program **Kaleidoscope Partial Hospital Program** 300 South St. Brookline, MA 02467	**Dedham Mental Health Partial Hospital Program** 980 Washington St, Suite 219 Dedham, MA 02026
Lowell Co-Occurring Partial Hospital Program 59 Lowe's Way, Suite 200 Lowell, MA 01851	**Woburn Co-Occurring Partial Hospital Program** **DBT-Informed Partial Hospital Program** 23 Warren Ave, Suite 140 Woburn, MA 01801

The following clinical documentation is recommended to facilitate transition into Partial Hospital Program Level of Care:

☐ Completed Referral Form

☐ Initial Psychiatric Evaluation

☐ One Week of Progress Notes

☐ Complete Biopsychosocial Assessment

☐ Full list of Psychiatric and Medical Medications

☐ Letters of Guardianship (if applicable)

I agree that the above information is accurate to the best of my knowledge, and I understand that any intentionally inaccurate information or omissions may result in this referral being declined.

Referral Source Signature: _____ Date: _____

Patient/Guardian Signature: _____ Date: _____