



Adolescent Partial Hospitalization Program (PHP) Referral

Date of Referral: _____

Requested Start Date: _____

Referral Name/Agency: _____

Phone: _____ Email: _____

DEMOGRAPHIC INFORMATION

Patient Name: _____ DOB: _____ Gender: _____

Preferred Pronouns: _____ Primary Language _____

Parent/Guardian: _____ Phone: _____

Address: _____

Primary Insurance: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

CLINICAL INFORMATION

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 school attendance, grades, & disciplinary history: _____

Describe current living situation: _____

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

SAFETY

Elopement: No Yes: _____

Suicidal ideation: No Yes: _____

Suicide attempts: No Yes: _____

Self-harm: No Yes: _____

Aggression/Violence: No Yes: _____

Fire-setting: No Yes: _____

Legal problems: No Yes: _____

Eating disorder: No Yes: _____

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

REFERRAL INFORMATION

Return completed referral forms to the preferred site via fax or call program with additional questions:

Lowell Adolescent Partial Hospital Program

Phone: 978-330-7680

Fax: 857-354-3360

Brookline Adolescent Partial Hospital Program

Phone: 617-676-3440

Fax: 857-354-3350

The following clinical documentation is highly 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

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: _____