



Adult Partial Hospitalization Program (PHP) Referral

Date of Referral: _____ Requested Start Date: _____

Interested in Virtual PHP and/or In-Person PHP Interested in Mental Health PHP and/or Dual Diagnosis PHP

Referral Source: _____ Phone: _____

Referral Source Agency: _____ Email: _____

Patient Name: _____ DOB: _____ Gender: _____

Address: _____ Phone: _____

Primary Insurance: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

Reason for referral: _____

Please describe the patient's ability to participate in groups & discharge planning: _____

Please describe relevant psychiatric & substance use history: _____

Current DSM-5/ICD-10 Diagnoses: _____

Legal Issues? Sex Offender? Eating Disorder? Can walk up stairs without any assistance?

Primary Care: _____ Phone: _____

Therapist: _____ Phone: _____

Prescriber: _____ Phone: _____

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

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

Suboxone: Dose: _____ Methadone: Dose: _____ Vivitrol: Next Injection Due: _____

Methadone/Suboxone Clinic Name & Location: _____ Phone: _____



PATIENT TO COMPLETE THIS SECTION

Please describe any history of psychiatric and/or substance use treatment with outcomes: _____

What is your current living situation? _____

What is your financial situation? Do you collect any subsidies (e.g., SSI, SSDI, food stamps, WIC, etc.)? _____

If accepted, what do you hope to get out of the program? _____

What is your post-discharge and housing plan from our program? _____

Describe your support system: _____

FOR DUAL DIAGNOSIS ADMISSION PATIENTS ONLY

What is your substance(s) of choice? _____

Date of last substance use: _____ Current length of sobriety: _____ Longest period of sobriety: _____

Have you every stayed in a sober house before? If yes, please describe: _____

COVID-19 QUESTIONNAIRE

Have you been fully vaccinated against COVID-19? _____ If you are not currently vaccinated, are you willing to get it? _____

If you have been vaccinated, which vaccine did you get? _____

Have you been in close physical contact in the last 14 days with anyone who is known or suspected to have COVID-19? _____

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

Referral Source Signature: _____ Date: _____

Patient Signature: _____ Date: _____

****For this referral to be complete, please include the initial psychiatric evaluation, at least one week of provider and nursing notes, a complete biopsychosocial assessment, and a full list of psychiatric and medical medications. If the patient is accepted to any of our in-person programs, we reserve the right to require a negative COVID-19 test prior to admission.****