BOURNEWOOD
HEALTH SYSTEMS

Adolescent 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: _____

Patient Name: _____ DOB: _____ Gender: _____

Address: _____ Phone: _____

Primary Insurance: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

REFERRAL SOURCE TO COMPLETE THIS SECTION

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? Has patient graduated from high school?

Primary Care: _____ Phone: _____

Therapist: _____ Phone: _____

Prescriber: _____ Phone: _____

Guardian: _____ Phone: _____

School: _____ Phone: _____

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

_____

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

_____

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PATIENT OR GUARDIAN TO COMPLETE THIS SECTION

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

_____

_____

Describe school attendance, grades, & disciplinary history: _____

_____

Describe treatment goals while in the program: _____

_____

What is your current living situation? _____

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:_____

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/Guardian 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.****

TWG 11/26/2021