BOURNEWOOD
HEALTH SYSTEMS
Support. Hope. Recovery.

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 willingness to participate in 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	**Brookline Adolescent Partial Hospital Program**
Phone: 978-330-7680	Phone: 617-676-3440
Fax: 857-354-3360	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 (Optional)

☐ 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: _____