BOURNEWOOD
HEALTH SYSTEMS
Support. Hope. Recovery.

Date of Referral:
Requested Start Date:

Referral to: ❑ Brookline Dual PHP: (p)617-676-3440 (f)857-277-5923
❑ Woburn PHP: (p) 781-932-0649 (f) 857-263-2838

Patient Name: ____________________________ Phone:______________________DOB:________ Gender:______

Address: ____

Primary Insurance: _____________________ Policy #:____

Secondary Insurance:____________________ Policy #:____

To Be Filled Out by Referral Source:

Referral Source: ____Phone: __________________________________

Reason for referral:

Relevant psychiatric or addiction history:

Is the patient able to participate in groups and actively participate in discharge planning? Please describe:

What is the patient's current level of motivation for participating in the Bournewood program?

Sober home needed? Explain? ____

Suboxone:__________ Methadone:__________ Dose_____________ Vivatrol __________Next injection due:___________

Clinic Name: ________________________ Location___________________________ Contact________________________

Next appointment Date: _______________________ Transportation to appointment? _________________________________

Legal Issues? ______________________________ Sex offender? Y or N_________ Eating D/O?_____________________

Current Medication: ____

Diagnosis/ICD 10: ____

PCP: ____ Phone: ____

Therapist: _______________________________________ Phone: ____

Prescriber: ______________________________________ Phone: ____

Aftercare post PHP: Please list aftercare referrals made:

1.____ 2.____

Please attach: ❑ Biopsychosocial ❑ List of medications ❑ recent notes ❑ psych assessment

1. Have you traveled outside of the United States in the past 3 months. If yes, where did you go?
2. Have you had a fever in the last 7 days?

Referral Source Signature: ____ Date: __________________________

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To Be Filled Out by Patient:

Please describe any past treatments and outcomes (i.e psychiatric inpatient, detoxes, MAT, outpatient counseling, etc).

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What is your current living situation? ____

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

____

____

What is your aftercare plan post discharge from the program? What is your housing plan? ________________

____

____

Who is your support system? ____

Date of last substance use?____________________ Substance of choice?_________________________

Current length of sobriety?____________________ Longest time sober?_________________________

Have you ever stayed in a sober house before? If yes, please describe. ____________________________

____

What is your financial situation? Do you collect any subsidies (for example, SSI, SSDI, food stamps, etc.)?

____

Patient Signature: ____Date:__________

For office use only: Accepted: _____ Yes ______ No _______ Pending (incomplete referral)

Date/Time of Intake: ______________________________ Canc/Rescheduled Date: __________________

❑ Patient attended scheduled intake ❑ Patient called to cancel ❑ Patient did not attend scheduled intake

Actions Taken: ❑ Call placed to patient ❑ Call placed to emergency contact ❑ Notified referring person

❑ Reviewed case with:______________________________ Notes: ________________________________

Signature:____ Date:________________ Time:

*Do Not File In Medical Record