



1153 Centre Street, Boston, MA 02130

PARTIAL HOSPITALIZATION PROGRAM
REFERRAL FORM *TELEHEALTH*****

Directions: -Please complete and fax this form with a **current biopsychosocial assessment** to psych triage at **617-983-4688**. Note: if referring from Partners eCare Facility, only complete * sections
 -You may call triage (617)983-7060 to confirm receipt and follow up on status
 -Patient will be contacted directly to schedule intake. Please encourage your patient to accept phone calls and return voicemails from triage. If your patient does not respond within 24 hours, they will be -removed from the active waitlist.

***Referral Source**

Name: _____
 Agency: _____
 Phone: _____
 Date of Referral: _____

***Client Information**

Name: _____
 MRN: _____
 DOB: _____ Gender: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____

***Insurance Information**

Primary Insurance: _____
 Policy #: _____
 Secondary Insurance: _____
 Policy #: _____

***Care Providers**

PCP: _____
 Phone: _____
 Fax: _____
 Therapist: _____
 Phone: _____
 Fax: _____
 Prescriber: _____
 Phone: _____
 Fax: _____

***Diagnosis**

Include ICD-10 codes

Current Medications

Include medication, dose & frequency

***Why does the patient require PHP level of care?**

***Goals for PHP:**

Past Psychiatric History

Current Mental Status

Safety Risks/Special Concerns

- Suicidal Ideation
- Self-Injurious Behavior
- Homicidal Ideation
- Violent Behavior
- Trauma
- Medication Non-Compliance

Describe any checked items:

***Discharge date (inpatient referrals only):**

Substance Use Information

	Specific Substance	First Use	Problem Age	Amount	Frequency	Last Use
Alcohol						
Amphetamines/Stimulants						
Benzodiazepines						
Cannabis						
Cocaine/Crack						
Opiates						
Tobacco						
Other						



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***I certify the patient meets the following admission criteria (must meet ALL):**

- **The patient is cognitively capable of participating in the treatment setting of four groups a day in addition to individual sessions with staff.**
- **The patient can manage self-care and function independently.**
- **The patient is medically stable.**
- **The patient is not a danger to self or others.**
- **The patient does not have any active psychotic symptoms that impede or limit ability to participate in group.**
- **The patient does not need detoxification treatment.**
- **The patient understands that the program is recovery focused and is motivated to work on recovery from alcohol and substances, if applicable.**
- **The patient agrees to provide toxicology screens (urine specimen or breathalyzer) upon request from staff.**
- **The patient understands length of stay in the program is based on medical necessity criteria.**
- **The patient must have access to zoom with video and audio (capable device with camera and microphone) and understand that the camera must remain on during groups.**
- **The patient must have active access to Partners Patient Gateway.**
- **The patient must provide active email:**
 - **Email address:** _____
- **The patient must provide address where they will be while attending the program:**
 - **Address:** _____
- **The patient must provide an emergency contact living with or near them and must sign a release for them.**
 - **Emergency Contact Name:** _____
 - **Emergency Contact Phone:** _____
- **For referrals coming from outside Brigham Health:**
 - **The patient has not had a serious suicide attempt within the past 6 months.**
 - **The patient has active therapist and/or prescriber who can collaborate in care. The patient must sign a release for providers.**

If patient is not able to commit to or doesn't meet the criteria above, please consider referral to another program.

For questions regarding the program please call us at: 617-983-7060

Clinician Signature: _____

BWFH staff use only: Psych ___ /Dual Dx___
Date: _____ Outcome: _____