Psychiatric Day Hospital Referral/Screening Form for Services

175 Harry S. Truman Pkwy, Annapolis, MD 21401
Phone: 667-204-7318 Fax: 667-204-7352

Date & Time of Scheduled PHP/IOP Assessment (To be completed by the PHP/IOP department)	
Date:	Time:

Services Referring to: ☐ *PHP or* ☐ *IOP*

Our goal is to respond to complete referrals within 24-48 business hours. In order to support this goal and the needs of the patient you are referring, please ensure the following:

- ❖ Please make sure that all sections of the referral are complete and legible
- ❖ Please provide recent clinical documentation to support this referral and your recommendation for this level of care

I. Information on Person/Provider Making Referral

Referring Provider's Name & Title:		Referring Agency's Name:
Referring Provider's Email:	Phone:	Fax:
Reason for Referral:		Date of Referral:

Referral from (Please Circle One):

Therapist/Counselor/Psychologist Psychiatrist/CRNP Emergency Department Inpatient

Primary Care Physician Specialist School Residential Treatment Other: _____

II. Information on Patient Being Referred for Services

Last Name, First Name, MI		DOB:	Gender:
Preferred Phone Number:	Secondary Phone:	Race:	Ethnicity:
Social Security #	Marital Status:	If applicable, electronic record member ID:	
Family Composition:		Family Contact #:	
Emergency Contact and Relation to Patient:		Emergency Contact #:	
If applicable, Legal Representative Name:		Legal Representative Contact #:	
Patient's Legal Address:	City:	State:	Zip:
Current Location (if different from above):			
Person/Parent/Guardian is aware of Referral: ☐ Yes ☐ No			
Patient's Preferred Spoken Language: Patient's Preferred Written Language:		List Any Special Communication Needs of the Patient:	
Is an interpreter needed? ☐No ☐Yes, language needed:		Cultural and Language Preferences: ☐No ☐Yes, please explain:	

If Applicable

Parent/Legal Guardian(s):

Are Parents Divorced or is there a Kinship/Guardianship Arrangement: ☐No ☐Yes, Please indicate below:

Who has Physical Custody?

Who has Legal Custody?

If Shared Custody, please list all individuals:

Additional information if needed:

III. Insurance Information

******MUST PROVIDE FRONT AND BACK COPY OF INSURANCE CARD******

☐ Patient is Uninsured If uninsured, non-par insurance, or no out-of-network benefits, will patient pay out of pocket? ☐ Yes ☐ No			
Primary Insurance:	Policy #: Group #:	Name of Policy Holder:	Relationship to patient:
Secondary Insurance:	Policy #: Group #:	Name of Policy Holder:	Relationship to patient:

IV: Psychiatric Diagnoses

_____

_____

V: Clinical Information (Presenting problem)

_____

_____

_____

VI. Clinical Goals for PHP

Primary Goal: _____

Secondary Goal: _____

VII. Risk Assessment

Please indicate if any of the following are current concerns within the past year

Suicidal thoughts	Homicidal thoughts	Aggression	Sexually-assaultive	Self-mutilating	Risk-taking behaviors
Eating disorder	Impulsive behaviors	Arson	Legal Involvement	Developmental Disorders	Substance Use

If **any of the behaviors in Section VII/Risk Assessment are checked, please elaborate: _____

_____

_____

VIII. Current Medications

Medication	Dose	Frequency

IV. Past Medication History (If known)
X. Current Chronic/Acute Medical Conditions

Seizures	Asthma	Diabetes	Other (please list)

**If any of the Conditions in Section X/Current Chronic/Acute Medical Conditions are checked, please elaborate: _____

_____

XI. Current Outpatient Treatment Providers that will be following patient

Psychiatrist/CRNP Name:	**Contact #:** **Fax #:**	**E-Mail Address:**
Therapist Name:	**Contact #:** **Fax #:**	**E-Mail Address:**
Other Provider, if Applicable:	**Contact #:** **Fax #:**	**E-Mail Address:**

☐ I Certify that this patient requires Partial Hospitalization or IOP to prevent decompensation and inpatient hospitalization, and that this patient cannot be managed adequately at the outpatient level of care.
☐ I have enclosed a copy of an authorization for release of information for this client and request that information regarding admission, treatment and discharge planning be share with me.

Signature of Referring Provider: _____ Date: _____ Time: _____

Dev: 1/16 **Rev:** 12/16; 1/17, 11/15/18, 11/20/18, 2/26/19, 3/4/19, 2/27/2020, 8/4/2020