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**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**V: Clinical Information (Presenting problem)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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, 12/22