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 ApplicableParent/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 UninsuredIf 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 | DevelopmentalDisorders | 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