D10438

Children's of Alabama

Patient Label

Partial Hospitalization Program Referral Form

Please complete the following document in its entirety and provide sufficient clinical criteria for admission.

DEMOGRAPHIC INFORMATION				
Patient Name: (First, Last)		Age:	Date of Birth:	
Address:	City:		State:	Zip:
Patient Preferred Language:				
Legal Guardian Name:		Phone Number:		
Legal Guardian Preferred Language:				
Address: *Please check if same as patient*: _____	City:		State:	Zip:
Guarantor Name: (*Please check if same as Legal Guardian*: _____		Phone Number:		

CLINICAL INFORMATION					
Provider Name:					
Address:	City:		State:	Zip:	
Phone:	Fax:	E-mail:			
Facility Name:					
Address:	City:		State:	Zip:	
Phone:	Fax:	E-mail:			
Check Box For Referral Reason (check all that apply)					
□ SI/Self Harm	□ Step down from inpatient	□ Step up from outpatient	□ Other		
Increase in one or more of the following symptoms despite outpatient treatment					
□ Depression	□ Psychosis	□ HI/SI	□ Aggression	□ OCD	□ Anxiety
At-Risk Behavior:		Other:			

How long has this crisis been going on? _____

DSM-V DX attach more dx to form if necessary	
Code:	Description:
Code:	Description:
Code:	Description:

History of Prior Mental Health Treatment ***(attach additional documentation if needed)***

Facility	***Dates/Age***	***Level of Care***	***Length of Stay***	***Successful Completion (y/n)***

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CLINICAL INFORMATION *(continued)*

History of Prior Mental Health Treatment ***(attach additional documentation if needed)***

Facility	*Dates/Age*	*Level of Care*	*Length of Stay*	*Successful Completion (y/n)*

Patient presents symptoms of eating disorder: □Yes □No

Does this patient have an active diagnosis of substance use disorder, severe? __□Yes □No

SOCIAL AND BEHAVIORAL HEALTH HISTORY

Current Behavioral Health Provider:

Phone:	Email:

Does the patient have a history of aggression or current aggression towards others? □Yes □No

Does the patient have a history of sexual perpetration? □Yes □No

If **Yes**, to either question please explain:

Does the patient have any current or pending legal charges that would prevent them from participating or attending treatment? □Yes □No

Does the patient have any history of legal involvement (Including DHR) □Yes □No

School Name:	Grade:	504 Plan: □Yes □No

Are there any developmental or cognitive delays that would impact participation in treatment?

□Yes □No If Yes, please explain:

Problems in School (check all that apply)

□ None	□ Tardiness	□ Motivation	□ Aggression	□ Peers
□ Truancy	□ Learning Ability	□ Fighting	□ Attention	□ Authority
□ Victim of Bullying	□ Substance Use	□ Concentration	□ Homework__	□ Bullying

□ Other:_____

Strengths in School:

Limitations in School:

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MEDICATIONS/MEDICAL HISTORY					
Primary Care Physician Name				Phone	
Allergies/Intolerances:	No☐	Yes☐	If yes, please list:		
Current Medications:	None☐	Yes	If yes please list below, attach documents if necessary.		

Name	*Dosage*	*Route of Admin*	*Last Dose*	*Indication*

Is patient compliant with medications?			Yes☐	No☐	If no, please explain:
Weight	Height	BMI:	Recent Change in Either?	Yes☐	No☐
If Yes, describe:					

Please indicate any other medical concerns of the patient

☐ None	☐ Seizures	☐ Asthma	☐Recent Head Trauma
☐Diabetic*	___ Cardiac	___Pregnant	☐Other

☐ **Suicide attempt in the last 72 hours**

* If diabetic and using insulin pump, pump must be removed and patient transitioned to shots in PHP.

If any checked, please describe:

Nursing Concerns:

☐None	☐Feeding Tube	☐ Wound Care	☐ Trach
☐ Incontinent	☐ Encropresis	☐ Fall risk	☐ Other

If checked or other, please describe:

Is the patient able to ambulate independently?	Yes___	No ___
If no, please describe:		
Is patient able to manage their ADL's without assistance?	Yes___	No ___

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Is patient willing to participate in treatment? ___ Yes ___ No
Is the caregiver willing to participate in treatment? ___ Yes ___ No

Please include any additional considerations not addressed in this form that may help us determine appropriateness for partial hospitalization:

_____

Please use this checklist to confirm all necessary information and documents have been provided prior to submission	
☐	Document is complete
☐	Document illustrates medical necessity for admission
☐	Patient appears at time of referral to have ability to participate in a group-focused php program.
☐	Patient currently does not present with another issue that requires more immediate intervention.
☐	Parent/guardian and patient in agreement on willingness to participate in treatment.
☐	Medication documented
☐	Necessary labs attached

Provider Name (print): _____ Date/ Time: _____
Provider Signature: _____

Forms can be faxed to 205-638-5061 or emailed to partialhospitalization@childrensal.org Please note acceptance of the patient is based on clinical and medical appropriateness.