ADULT PARTIAL HOSPITALIZATION PROGRAM
2617 West Henrietta Road Rochester, NY 14623
Phone (585) 276-7620 Fax (585) 256-2805

REFERRAL FORM

PATIENT: _____ DOB: _____ Sex: _____

Address: _____ Phone #: ( ) _____

INSURANCE: Coverage: _____ Contract #: _____

Patient's chief complaint: _____

Referrer's reason for referral and goal for PHP admission: _____

_____

Current Diagnostic Impression (DSM-5)

- Please list **primary diagnosis FIRST**
- Note: **excluded diagnoses** include Adjustment Disorder only if Medicare recipient, Primary Substance Use Disorder, Neurocognitive Disorder (dementia), Primary Neurodevelopmental Disorder, IQ under 70

_____

_____

RISK FACTORS: (check all that apply, include additional info in clinical documentation sent with referral)

	Current	**Past**		**Current**	**Past**
Suicidal ideation			Violent or threatening		
Suicide attempt			Poor impulse control		
Self-injury			Legal system involvement		
Homicidal ideation			Poor boundaries in treatment setting		
Affective instability			Aggression in a treatment setting		
Psychosis			Learning disability		
History of trauma			Needs interpreter *(specify)*:		
Eating disorder			Other *(specify)*:		
Medical problems					
Psychosocial stressors					
Potential barriers to PHP treatment					

	Current	**Past**	**Last Use Date**	**Most recent amount, frequency, duration**
Alcohol use				
Substance use (specify for each substance)				
Ability to stop/motivation to address in treatment:				

MEDICATIONS:

☐ Check box if medication flow sheet (which includes this information) is being faxed along with referral form. Otherwise, please complete the following two sections.

Current Medications:

Name of Medication	Dose/Frequency	Duration of treatment with this medication

Past Medication History:

Name of Medication	Dose/Frequency	Reason for discontinuation

Allergies/Adverse Drug Reactions: _____

Are there any recommendations from the patient's prescribing provider for medication changes while in PHP?

_____

_____

CURRENT TREATMENT PROVIDERS (include phone numbers if available):

Psychiatrist: _____ Therapist: _____

Care Manager: _____ Primary Care Doctor: _____

Outpatient Program/Group: _____ Other *(specify)*: _____

REFERRING PERSON: _____ Phone: ( )_____

Address: _____ Fax: ( ) _____

Agency/Program: _____

☐ Referral must be accompanied by a current clinical summary.
☐ Referral must either have an attached medication flow sheet or the completed medication list above.
☐ It is the expectation that all patients referred to PHP will return to their current treatment providers upon discharge from PHP.