MR#_____
(OFFICE USE ONLY)

CHILD AND ADOLESCENT PARTIAL HOSPITALIZATION SERVICE (CAPHS)

DEPARTMENT OF PSYCHIATRY

OUTSIDE OF MONROE COUNTY FORM

Phone (585) 273-1779 Fax (585) 273-1386

Email - ChildandAdolescentPartialIntakeTeam@URMC.Rochester.edu

PATIENT: _____ DOB: _____ Age: _____ Gender: _____ Ethnicity: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

School: _____ Special Education? _____ Grade: _____

PARENT /GUARDIAN:

Name	Relationship to Patient	Home Number	Work Number

INSURANCE:

Coverage: _____ Contract #: _____

Primary Care Physician: _____ Phone #: _____

CLINICAL DATA:

Mental Health Diagnosis: _____

Mental Health Diagnosis: _____

Medical Concerns: _____

Psychosocial Stressors: (Z Codes) _____

Has patient had any prior psychiatric hospitalizations? If yes, specify when & where:

_____

_____

CURRENT PSYCHOTROPIC MEDICATIONS: (Past Trials/ Current Regimen)

Medication	Dosage	Target Symptoms	Response	Start Date	End Date

Referral must be accompanied by a copy of a current clinical summary and a signed release of information form.

RISK FACTORS:

	Current Episode	Past History		Current Episode	Past History
Affective instability	☐	☐	Poor impulse control	☐	☐
Alcohol/substance abuse	☐	☐	Property destruction	☐	☐
Anorexia	☐	☐	School avoidance	☐	☐
Anxiety	☐	☐	School problems	☐	☐
Bulimia	☐	☐	Self-mutilation	☐	☐
Depression	☐	☐	Sexual acting out	☐	☐
Eating problems	☐	☐	Sleeping problems	☐	☐
Encopresis / Enuresis	☐	☐	Social withdrawal	☐	☐
Hallucinations/delusions	☐	☐	Suicidal ideation	☐	☐
Hyperactive/inattentive	☐	☐	Suicide attempt	☐	☐
Language processing/LD	☐	☐	Temper outbursts	☐	☐
Low cognitive functioning/MR	☐	☐	Thought disorder	☐	☐
Oppositional/defiant	☐	☐	Threatening	☐	☐
Physically assaultive	☐	☐	Poor impulse control	☐	☐

DOES THE PATIENT HAVE DIABETES/ASTHMA OR ANY OTHER MEDICAL ISSUE? ☐ **Yes** ☐ **No**

If yes, what is the medical issue and who are the providers? _____

CPS/ LEGAL INVOLVEMENT: _____

_____

GROUP EXPERIENCE: How does patient do in group? _____

_____

PATIENT'S CHIEF COMPLAINT: _____

_____

THERAPIST/PROVIDERS REASON FOR REFERRAL:

_____

Referring Provider:
Name: _____ Phone: _____ Fax: _____
Address:

Referral must be accompanied by a copy of a current clinical summary and a signed release of information form.

CURRENT TREATMENT PROVIDERS:

Outpatient Therapist: Yes / No
Name: _____ Phone: _____ Fax: _____
Address:

Outpatient Psychiatrist: Yes / No
Name: _____ Phone: _____ Fax: _____
Address:

Case Manager: Yes / No
Name: _____ Phone: _____ Fax: _____
Address:

Additional Emergency Contacts: Yes / No
Name: _____ Phone: _____ Fax: _____
Address:

LOCAL EMERGENCY SERVICES:

Psychiatric Mobile Crisis Team: Yes / No
Name: _____ Phone: _____ Fax: _____
Address:

Psychiatric Emergency Department: Yes / No
Name: _____ Phone: _____ Fax: _____
Address:

Local Suicide Hotline: Yes / No
Name: _____ Phone: _____ Fax: _____
Address:

Other Local Emergency Services: Yes / No
Name: _____ Phone: _____ Fax: _____
Address:

***In order for your patient to be eligible for Partial Hospitalization Via Telehealth, the patient must have**

- Access and availability to consistent internet (ex: hotspot, broadband, Wi-Fi)
- Access to a devise with a working camera and microphone (ex: Computer, Chromebook, Tablet, Smartphone)
- A private place to engage in individual and group therapy
- Willingness to engage in treatment – sitting up and dressed daily.
- A responsible adult in the home to assist in mobilization of the patient, support with implementation of coping strategies, fielding phone calls from the treatment team, and ability to respond in an emergency situation.

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