Mass General Brigham
Brigham and Women's Faulkner Hospital

PARTIAL HOSPITALIZATION PROGRAM REFERRAL FORM

1153 Centre Street, Boston, MA 02130

Directions:

- Please complete and fax this form with a **current biopsychosocial assessment** to psych triage at **617-983-4688**
- **Note: if referring from Partners eCare Facility, only complete * sections**
- You may call triage (617)983-7060 to confirm receipt
- Patient will be contacted directly to schedule intake

***Referral Source**

Name:
Agency:
Phone:
Date of Referral:

***Client Information**

Name:
MRN:
DOB: Gender:
Address:
City: State: Zip:
Phone:

***Insurance Information**

Primary Insurance:
Policy #:
Secondary Insurance:
Policy #:

***Care Providers**

PCP:
Phone:
Fax:
Therapist:
Phone:
Fax:
Prescriber:
Phone:
Fax:

***Diagnosis**
Include ICD-10 codes

Current Medications
Include medication, dose & frequency

***Why does the patient require PHP level of care?**

***Goals for PHP:**

Past Psychiatric History

Current Mental Status

Safety Risks/Special Concerns

- ☐ Suicidal Ideation
- ☐ Self-Injurious Behavior
- ☐ Homicidal Ideation
- ☐ Violent Behavior
- ☐ Trauma
- ☐ Medication Non-Compliance

Describe any checked items:

***Discharge date (inpatient referrals only):**

Substance Use Information

	Specific Substance	First Use	Problem Age	Amount	Frequency	Last Use
Alcohol						
Amphetamines/Stimulants						
Benzodiazepines						
Cannabis						
Cocaine/Crack						
Opiates						
Tobacco						
Other						

Mass General Brigham
Brigham and Women's Faulkner Hospital

1153 Centre Street, Boston, MA 02130

PARTIAL HOSPITALIZATION PROGRAM REFERRAL FORM

***I certify the patient meets the following admission criteria (must meet ALL):**

☐ **The patient is cognitively capable of participating in the treatment setting of four groups a day in addition to individual sessions with staff.**

☐ **The patient can manage self-care and function independently.**

☐ **The patient is medically stable.**

☐ **The patient is not a danger to self or others.**

☐ **The patient does not have any active psychotic symptoms that impede or limit ability to participate in group.**

☐ **The patient does not need detoxification treatment.**

☐ **The patient understands that the program is recovery focused and is motivated to work on recovery from alcohol and substances, if applicable.**

☐ **The patient agrees to provide toxicology screens (urine specimen or breathalyzer) upon request from staff.**

☐ **The patient understands length of stay in the program is based on medical necessity criteria.**

☐ **The patient must have active access to Partners Patient Gateway.**

☐ **The patient must provide address where they will be while attending the program:**
Address: _____

☐ **The patient must provide an emergency contact living with or near them and must sign a release for them.**
Emergency Contact Name: _____

Emergency Contact Phone: _____

For referrals coming from outside Brigham Health:

☐ **The patient has not had a serious suicide attempt within the past 6 months.**

☐ **The patient has active therapist and/or prescriber who can collaborate in care. The patient must sign a release for providers.**

If patient is not able to commit to or does not meet the criteria above, please consider referral to another program.

For questions regarding the program please call us at: 617-983-7060

Clinician Signature: _____

BWFH staff use only: Psych __ /Dual Dx__
Date: Outcome: