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** |  |  |  |  |  |  |

**\*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: