Lindner Center of HOPE®
4075 Old Western Row Rd., Mason, Ohio 45040

External Referral Form for Services

Once form is complete, print and fax to (513) 536-0509, call Lindner Center of HOPE at (513) 536-HOPE (4673), state you are a referrer and ask for intake to continue referral process.

Date of Referral: _____

Demographic Information			
Name of Patient:		DOB:	
Address:			
Best Contact #:		Email:	

Insurance Information			
Insurance Co.:			
ID#:		Group #:	
Subscriber Name:		DOB:	
# To Verify Benefits:			

Referral Source			
Referrerl Name:			
Agency:			
Phone/Fax:		Email:	
How long have you had a clinical relationship with this patient?			

Clinical Information	
Brief Current Update	
Clinical Goals for PHP	
Primary Goal:	
Secondary Goal:	
Current Diagnosis	
I:	
II:	
III:	
IV:	
V:	
Previous Inpatient and/or detox hospitalizations: Specify dates, facilities and brief reason:	
Trauma History	

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ADULT PARTIAL HOSPITALIZATION SERVICES
EXTERNAL REFERRAL FORM FOR SERVICES

Substance Abuse History (please include nicotine usage)	
Longest Period of Sobriety / When?	
Current Medication(s) and Dosages (name/dose)	
Do you feel patient is medication compliant ?	
If no, please explain.	
Are you looking for medication adjustments/recommendations?	
If so, preferred communication of changes/recommendations?	
Current Chronic/Acute Medical Conditions	
Allergies (please list all including food and/or environmental)	

Current Outpatient Treatment Team:			
Psychiatrist:		Other:	
Therapist		Other:	
Primary Care:			

Behavioral Issues:		
	Active:	Past (when?):
Binge Eating		
Purging (self-induced vomiting)		
Self-Harm (cutting, burning etc.)		
Excessive Exercise		
Other (specify)		

Comments/Other Relevant Information: