LINDNER CENTER OF HOPE

Adolescent Partial Hospital Program Request Form

Name: ______________________________

DOB: ______________________________

MRN: ______________________________

Please complete this paperwork to the best of your ability. Providers may supplement information with chart documentation that supports clinical criteria for admission to partial hospitalization level of care. Please fax/scan to **513-536-0110** or **Adolescent-PHP@lindnercenter.org** for review. Outpatient assessments for potential candidates can be requested by providers and families via **513-536-0KID (0543)**.

SECTION I: DEMOGRAPHICS

Patient's Name: ______________________ Date of Birth: ______________ Pronouns: ________

Patient Address: ____

____

Legal Guardian Name: ______________________ Primary Contact Number: ______________

Is the guardian able to participate in admission and family meetings: ☐ No ☐ Yes

Insurance Company Name: ____

SECTION II: CLINICAL INFORMATION

Referring Provider Name: ______________________ Affiliation: ______________

Phone: ____

Email: ____

Please explain the reasons for referral: ____

____

____

DSM-5 Diagnoses (if known): ____

SECTION III: SOCIAL AND BEHAVIORAL HEALTH HISTORY

Current Behavioral Health Provider(s): ____

____

Does patient have a history of aggression or current aggression towards others? ☐ No ☐ Yes

If yes, explain: ____

____

School Name: ______________________ Grade: ______________

IEP or 504 Plan ☐ No ☐ Yes ☐ Unknown

Are there any concerns for developmental or cognitive delays? ☐ No ☐ Yes

If yes, explain: ____

____

____

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SECTION III: SOCIAL AND BEHAVIORAL HEALTH HISTORY

Please explain any problems with school:

____

____

SECTION IV: MEDICATION/MEDICAL HISTORY

Primary Care Physician Name: ______________________________ Phone: ____________________

Allergies/Intolerances: ☐ No ☐ Yes If yes, describe: ______________________________

Current medications: ☐ None ☐ Yes, please list below

Name	Dosage	When Med Started	Date/Time of Last Dose	Indication

Past psychiatric medications, if known: ______________________________

____

Recent change in weight: No ☐ Yes ☐

If yes, describe: ______________________________

____

Has the patient ever been diagnosed with an eating disorder? ☐No ☐Yes *Not accepting EDO dx at this time

Medical Concerns: ☐ None ☐ Diabetic* ☐ Seizure disorder ☐ Asthma ☐ Recent head trauma
☐ Cardiac ☐ Pregnant ☐ Special Diet: ____________________
☐ Suicide attempt in the last two weeks that needed medical intervention
☐ Other: ______________________________

If any checked, describe: ______________________________

If the patient has an insulin pump, it must be removed and the patient must be converted to injections prior to admission

Fall risk

Nursing Concerns: ☐ None ☐ Wound Care

Describe specific nursing needs: ______________________________

Is patient able to ambulate independently? ☐ No ☐ Yes

If no, describe: ______________________________

Is patient able to manage their ADL's? ☐ No ☐ Yes

If no, describe: ______________________________

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Please use this checklist to confirm you have completed and provided all necessary information:	
☐ Yes ☐ No	Document is complete
☐ Yes ☐ No	Document illustrates medical necessity for admission
☐ Yes ☐ No	Parents/Guardian in agreement
☐ Yes ☐ No	Attached is a copy of the front and back of patient's insurance card
☐ Yes ☐ No ☐ N/A	Medication documented

____

Signature of provider completing form/Credentials Printed Name Date/Time

LCOH use only:

____

Form reviewed by signature Printed Name Date/Time