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