



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: _____
Member ID#: _____ Guaranteer DOB: _____

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

Has the patient ever been diagnosed with an eating disorder? No Yes

If yes, describe: _____

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*

Nursing Concerns: None Wound Care Fall risk

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:		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Document is complete
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Document illustrates medical necessity for admission
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Parents/Guardian in agreement
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Attached is a copy of the front and back of patient's insurance card
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A Medication documented

Signature of provider completing form/Credentials	Printed Name	Date/Time
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LCOH use only:

Form reviewed by signature	Printed Name	Date/Time
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