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: ____________________

____

LINDNER CENTER OF HOPE

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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:			
☐ 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