Lindner Center of HOPE | UC Health

Adolescent Partial Hospital Program Request Form

Name: _____

DOB: _____

MRN: _____

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	[illegible]	Date/Time of Last Dose	Indication

Past psychiatric medications, if known: _____

_____

Recent change in weight: No ☐ Yes ☐

If yes, describe: _____

_____

SECTION IV: MEDICATION/MEDICAL HISTORY (continued)

Has the patient ever been diagnosed with an eating disorder? ☐ No ☐ Yes *[illegible]

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