Lindner Center of HOPE | UC Health

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 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: ______________________
____

SECTION IV: MEDICATION/MEDICAL HISTORY (continued)

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