

FULLER HOSPITAL
Partial Hospitalization Program Referral Form
Phone (508) 838-2337 Fax Referral to: (508) 838-2326

Date: Referring Facility: Referring Staff/Case Manager: Referring Staff Phone #:	Patient Name: DOB: SS#: Gender:	Guardianship: Identifying Gender:
Insurance Company: Policy ID #:	If applicable: Secondary Insurance: Policy #:	
Psychiatric/Substance Diagnosis: Medical Diagnosis: Psycho Social Stressors:	Date of MOST RECENT suicide attempt and method: Date of most recent SI/HI/SIB; superficial or required sutures: Please describe any current signs of AH/VH or psychosis:	
1. Is the patient presently prescribed Benzodiazepines or opiates? 2. Is the patient presently prescribed muscle relaxers and/or opiates? 3. Is the patient currently on Methadone Maintenance? 4. Is the patient presently prescribed Suboxone? If So, please provide a letter of good standing from an outside provider along with a follow-up appointment. 5. Is the patient receiving injectable medications?	Date of last restraint/seclusion if applicable: If So, please explain	
Will the patient return home? If not, please describe the patient's current living situation: Does patient receive income for sober placement (ie SS/Disability)?:	History/Active Eating Disorder: Legal Issues:	

Pt's aftercare plan BEYOND PHP:

Sex offender: yes no If so, what level? 1 2 3
(please circle one)

Outpatient therapist:

Trauma History:

Outpatient Psychiatrist:

Substances of choice/current length of sobriety:

Primary Care Physician:

List the referral you have made for placement BEYOND PHP:

List acute clinical issues/rationale for PHP Level of Care:

1
2

List other appointments/involvement (DMH, CSP, SOAP, etc)

Please provide a full list of current medications w/ doses and frequency.

Please attach the Dr.'s current patient med list and psychosocial assessment.

If the patient is receiving Suboxone, please provide a letter of good standing with outside provider.