THE INSPIRE PROGRAM AT FULLER HOSPITAL
LEADING THE WAY IN BEHAVIORAL HEALTH

ADOLESCENT PARTIAL FAX REFERRAL FORM

FAX: 508-838-2326 **PHONE:** 508-838-2337 **EMAIL:** FULLERPARTIALPROGRAM@UHSINC.COM

The Inspire Program at Fuller Hospital is a short-term intensive group therapy program for adolescent's ages 12 to 18* years old (so long as they are enrolled in school).

The program runs Monday – Friday from 9am to 3pm **in-person** or **online through Telehealth**.

Fuller's adolescent **Partial Hospitalization Program** (PHP) provides intensive group therapy, case management, psychiatric care, and family support.

In-Person participants will attend groups and meet with a clinician and provider during that time. Intake appointments are at 9am. Patients should plan on staying the full 6 hours on their first day.

Telehealth allows families to get the services they need in the comfort of their home; sessions are not a recording or webinar, instead it is a session in real time, with real people.

PLEASE CHECK ONE: I WISH TO PARTICIPATE IN TREATMENT THROUGH ☐ **TELEHEALTH (**ONLINE & IN REAL TIME) ☐ **IN PERSON**

COMPLETED FORMS CAN BE FAXED **508-838-2326** -OR- EMAILED **FULLERPARTIALPROGRAM@UHSINC.COM**

DEMOGRAPHIC INFORMATION				
Patient's Name:			Date:	
DOB:	SSN:	Phone #:		
Primary Language:	Gender:	Age/Grade:		
Address:	City:	State:	Zip:	
Guardian's name:	Relationship:			
Address:	City:	State:	Zip:	
Phone:	Email:			
Guardian's Primary Language:	If not, preferred language:			
Who to contact w/ appointment information (name/number):				
Legal Guardian (if different than custodial guardian):				
Phone:	Email:			
Does the individual have any of the following services? ☐ DCF ☐ DMH ☐ DYS ☐ DDS				
If so, please document names, roles, and contact number:				

INSURANCE INFORMATION	
Primary Insurance:	Policy #:
Subscriber Name:	Relation/DOB:
Secondary Insurance:	Policy #:
Subscriber Name:	Relation/DOB:

CLINICAL INFORMATION	
(check all that apply) **Presenting Problem(s):** ☐ Anxiety ☐ Depression ☐ Substance Use ☐ Other	
Describe:	
(check all that apply) **Psychological Stressors:** ☐ Social Environment ☐ Educational ☐ Housing ☐ Economic ☐ Legal ☐ Primary Support/Family ☐ Access to healthcare	
Reason for Referral:	
Precipitants to Referral (family, friends, school stressors? Recent upsetting events? High Risk factors?)	
Current Medications and Doses:	
Psychiatric Diagnosis:	
Medical Diagnosis:	
Diagnosed with an eating disorder? ☐ No ☐ Yes (If "Yes" please answer questions on next line)	
If "Yes", please provide Diagnosis:	Is this current? ☐ Yes ☐ No
Accommodations Needed:	
Any Cognitive/Intellectual Disabilities?	Independent with Self-Care?
Is this a step down from inpatient?	Discharge Date:
PROVIDER INFORMATION	
Therapist: ☐ Yes ☐ No (Check One)	
Name:	
Phone number:	Fax number:
Address:	
Med Prescriber: ☐ Yes ☐ No (Check One)	
Name:	
Phone number:	Fax number:
Address:	
PCP/Pediatrician: ☐ Yes ☐ No (Check One)	
Name:	
Phone number:	Fax number:
Address:	
ADDITIONAL INFORMATION	
School Presently Enrolled:	
Address:	
Contact Person:	Phone number:
Email address:	
REFERRAL INFORMATION	
Name of referring agency/facility:	
How did you hear about Fuller PHP?	
Contact Person:	Phone number:
Email address:	