



ADOLESCENT PARTIAL FAX REFERRAL FORM

*****PLEASE CALL 781-829-7121 TO SCHEDULE AN APPOINTMENT PRIOR TO SUBMITTING THIS FORM.*****

The **Adolescent Partial Hospitalization Program at Pembroke Hospital** is a short-term (1-3 week) intensive group therapy program for adolescent's ages 13 to 18* years old (so long as they are enrolled in school).

The program runs Monday – Friday from 9am to 2pm **Online through Telehealth** currently.

In person is TBD due to COVID-19 pandemic. **Intake appointments can be scheduled via telehealth or in person.**

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

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. **Parents/guardians must be reachable in case of an emergency..**

PLEASE CHECK ONE: I WISH TO SCHEDULE INTAKE THROUGH TELEHEALTH (ONLINE & IN REAL TIME) IN PERSON

Completed forms can be FAXED: 781-795-9934 or EMAILED: INTAKE.ONE@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? <input type="checkbox"/> DCF <input type="checkbox"/> DMH <input type="checkbox"/> DYS <input type="checkbox"/> 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:	
INTAKE OFFICE USE ONLY			
Insurance verified? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date/Person:	
Initial Authorization#		Start Date:	End Date: Units:
Reviewer Name:		Reviewer Phone:	

CLINICAL INFORMATION	
(check all that apply) Presenting Problem(s): <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Substance Use <input type="checkbox"/> Other	
Describe:	
(check all that apply) Psychological Stressors: <input type="checkbox"/> Social Environment <input type="checkbox"/> Educational <input type="checkbox"/> Housing <input type="checkbox"/> Economic <input type="checkbox"/> Legal <input type="checkbox"/> Primary Support/Family <input type="checkbox"/> 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:	
Accommodations Needed:	
Any Cognitive/Intellectual Disabilities?	Independent with Self-Care?
Is this a step down from inpatient?	Discharge Date:
PROVIDER INFORMATION	
Therapist: <input checked="" type="radio"/> yes <input type="radio"/> no	
Name:	
Phone number:	Fax number:
Address:	
Med Prescriber: yes or no (circle one)	
Name:	
Phone number:	Fax number:
Address:	
PCP/Pediatrician: <input checked="" type="radio"/> yes <input type="radio"/> no	
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 Pembroke PHP?	
Contact Person:	Phone number:
Email address:	
INTAKE OFFICE USE ONLY	
Call entered into MS4? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date/Person:
Intake Appointment Scheduled <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Telehealth <input type="checkbox"/> In-Person
Date:	<input type="checkbox"/> 8 am <input type="checkbox"/> 9 am <input type="checkbox"/> 10 am <input type="checkbox"/> 11 am <input type="checkbox"/> 2 pm <input type="checkbox"/> 3 pm
Reminder Calls <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd	Phone number: