ADOLESCENT PARTIAL FAX REFERRAL FORM

*****PLEASE CALL 781-829-7121 TO SCHEDULE AN APPOINTMENT PRIOR TO FAXING 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 to 781-795-9934

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:		
*****INTAKE OFFICE USE ONLY*****			
Insurance verified? ☐ Yes ☐ No	**Date/Person:**		
Initial Authorization#	**Start Date:**	**End Date:**	**Units:**
Reviewer Name:	**Reviewer Phone:**		

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:	
Accommodations Needed:	
Any Cognitive/Intellectual Disabilities?	Independent with Self-Care?
Is this a step down from inpatient?	Discharge Date:
Provider Information	
Therapist: ◯ yes ◯ no	
Name:	
Phone number:	Fax number:
Address:	
Med Prescriber: yes or no (circle one)	
Name:	
Phone number:	Fax number:
Address:	
PCP/Pediatrician: ◯ yes ◯ 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? ☐ **Yes** ☐ **No**	**Date/Person:**
Intake Appointment Scheduled ☐ **Yes** ☐ **No**	☐ **Telehealth** ☐ **In-Person**
Date:	☐ **8 am** ☐ **9 am** ☐ **10 am** ☐ **11 am** ☐ **2 pm** ☐ **3 pm**
Reminder Calls ☐ **1st** ☐ **2nd** ☐ **3rd**	**Phone number:**