Partial Hospital Program Request Form

Psychiatric Intake Response Center Phone: (513) 636-4124 Fax: (513) 803-8173

Name: ____________________

DOB: ____________________

MRN: ____________________

Please complete the document in its entirety and provide enough information to support clinical criteria for admission to a partial hospital program. Please fax completed document to (513) 803-8173 for our review. Acceptance of your patient is based on clinical and medical appropriateness.

Requesting: ☐ Green Township ☐ Norwood

SECTION I: DEMOGRAPHICS

Patient's Name: ____________________ Date of Birth: ____________ Age: ________

Patient Address: ____________________

____

Legal Guardian Name: ____________________ Primary Contact Number: ____________

Is the guardian able to participate in admission and family meetings: ☐ No ☐ Yes

Insurance Company Name: ____________________ *(CareSource is the only accepted Medicaid)*

SECTION II: CLINICAL INFORMATION

Provider Name & Credentials: ____________________ Agency/Facility Name: ____________

Phone: ____________________ Phone (after hours): ____________________

Email: ____________________

Please check the boxes indicating the reasons for referral:

☐ Self-injury ☐ School refusal ☐ Increased in level of care/inpatient diversion

☐ Decrease in ADL's ☐ Other: ____________________

Increase in psychiatric symptoms despite outpatient treatment:

☐ Depression ☐ Anxiety ☐ Psychosis ☐ Homicidal Ideation ☐ Suicidal Ideation

☐ Aggression ☐ Risky behavior ☐ OCD ☐ Other: ____________________

For each check box, please provide description: ____________________

____

____

____

What interventions have been attempted? ____________________

____

____

How long has this crisis been going on? ____________________

DSM-5 Diagnoses:

1. ____________________ Severity: ☐ Slight ☐ Mild ☐ Moderate ☐ Severe

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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: ______________________

____

____

Problems with school? ☐ None ☐ Peers ☐ Attention ☐ Concentration
☐ Tardiness ☐ Truancy ☐ Authority ☐ Homework ☐ Motivation
☐ Learning Ability ☐ Victim of Bullying ☐ Bullying ☐ Aggression ☐ Fighting

☐ Other: ______________________

Strengths in School: ______________________

Limitations in 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	Route of Administration	Date/Time of Last Dose	Indication

Is patient compliant with medications? ☐ No ☐ Yes

If no, describe: ______________________

History of psychiatric medications, if known: ______________________

____

Weight: ____________ Height: ____________ Recent change in weight: ☐ No ☐ Yes

If yes, describe: ______________________

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SECTION IV: MEDICATION/MEDICAL HISTORY (continued)

Does patient have an eating disorder? ☐ No ☐ Yes *Not accepting EDO patients at this time.*

a. Current Ideal Body Weight: _______________ BMI: _______________

b. Orthostatic Vital Signs: Sitting Blood Pressure: _________________ Heart Rate: ___________________

Standing Blood Pressure: ________________ Heart Rate: ___________________

c. Please attach all labs/tests demonstrating medical clearance for Eating Disorders,including:
- EKG - completed within the last 7 days
- CBC w/differential - completed within the last 3 days
- Basic metabolic profile + phos + mag - completed within the last 3 days
- Hepatic profile TSH with reflex T4 - completed within the last 3 days

Medical Concerns: ☐ None ☐ Diabetic* ☐ Seizure disorder ☐ Asthma ☐ Recent head trauma
☐ C-Pap for Sleep ☐ Dialysis ☐ Cardiac ☐ Pregnant ☐ Inability to swallow pills
☐ Suicide attempt in the last two weeks that needed medical intervention
☐ Other: ____

If any checked, describe: ____

**If the patient is on an insulin pump, the pump must be removed and the patient must be converted to injections prior to admission*

Nursing Concerns: ☐ None ☐ Feeding Tube ☐ Wound Care ☐ Incontinent ☐ Encopresis ☐ Fall risk ☐ Trach

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: ____

____

Signature of provider completing form/Credentials Printed Name Date/Time

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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
☐ Yes	☐ No	☐ N/A	Labs, including EKG attached (Required for any Eating Disorder diagnosis)

CCHMC use only:

Form reviewed by signature | Printed Name | Date/Time