



Partial Hospital Program Request Form

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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 Lindner Center of Hope

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: <input type="checkbox"/> No <input type="checkbox"/> Yes		
Insurance Company Name:		

SECTION II: CLINICAL INFORMATION	
Provider Name & Credentials:	Agency/Facility Name:
Phone:	Phone (after hours):
Email:	
Please check the boxes indicating the reasons for referral:	
<input type="checkbox"/> Self-injury	<input type="checkbox"/> School refusal <input type="checkbox"/> Increased in level of care/inpatient diversion
<input type="checkbox"/> Decrease in ADL's	<input type="checkbox"/> Other: _____
Increase in psychiatric symptoms despite outpatient treatment:	
<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Psychosis <input type="checkbox"/> Homicidal Ideation <input type="checkbox"/> Suicidal Ideation	
<input type="checkbox"/> Aggression <input type="checkbox"/> Risky behavior <input type="checkbox"/> OCD <input type="checkbox"/> Other: _____	
For each check box, please provide description:	
What interventions have been attempted?	
How long has this crisis been going on?	
DSM V Diagnoses:	
1. _____	Severity: <input type="checkbox"/> Slight <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> 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 If Yes, complete a-c:

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 demonstrating medical clearance for eating disorder, including EKG.

- 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

Please use this checklist to confirm you have completed and provided all necessary information:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Document is complete
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Document illustrates medical necessity for admission
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Parents/Guardian in agreement
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Attached is a copy of the front and back of patient's insurance card
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A Medication documented
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A Labs, including EKG attached

CCHMC use only:

Form reviewed by signature Printed Name Date/Time