CHI St. Alexius Health

BHO020

BEHAVIORAL SERVICES

PARTIAL HOSPITALIZATION PROGRAM REFERRAL

Date		SSN	
Patient Name		Date of Birth	Age
Parent/Guardian		Patient Phone Number ( )	
Insurance		Legal Status ☐ Voluntary ☐ Involuntary ☐ Ward of State ☐ Minor	
Referral Source ☐ Inpatient ☐ Outpatient ☐ Emergency Department ☐ Community Entity: _____	Phone Number	Transportation	
Date of Inpatient Admit	IQ Status if available:	Primary Care Physician	
Outpatient Psychiatrist		Therapist	

PRESENTING PROBLEMS
(Home Behavior, School Problems, Medication Compliance, Aggression, Suicidal Ideation, Homicidal Ideation, Hallucinations

Suicidal Ideations:

Homicidal Ideations:

Assaultive (any seclusion and restraints):

History of Abuse:

Substance Abuse:

MEDICAL PROBLEMS

Assessment Date and Time	Admission Date and Time

Follow-Up Notes:

Accepting Physician: ☐ Dr. Dahmen

Signature	Date	Time