Adolescent Partial Hospitalization Program
105 Mary's Avenue, One North, Kingston, New York 12401
Telephone (845) 334-3110 Fax (845) 334-4972

REFERRAL FORM FOR ADOLESCENT PHP

The Adolescent Partial Hospitalization Program (APHP) is a voluntary, intensive, short-term multi-disciplinary psychiatric treatment program for adolescents. Individuals who are admitted must be at risk of psychiatric hospitalization or be transitioning from an inpatient stay to the community. APHP is designed in compliance with NYSOMH and DNV standards to provide an alternative to inpatient treatment for persons with acute symptoms, meeting medical necessity criteria, who can be safely treated with less than 24 hours of daily care.

The major treatment focus is symptom reduction through medication management and the acquisition of coping skills through group therapy. Dialectical Behavior Therapy is the main treatment modality. A psychiatric provider manages medication and directs the treatment team. Mental health clinicians provide supportive individual therapy, group therapy, family therapy, case management and advocacy.

Please sign and date after checking off all boxes indicating verification that admission criteria has been satisfied prior to faxing referral and supporting documentation to PHP for review.

Name:________________________________DOB:_________________SS#:____________________

Address:______________________________,_____________________,____________,___________
PO or Street City State Zip Code

Telephone:________________________ Cell:____________________

Parent / Legal Guardian:___________________________, __________________, ____________________
Name Relationship Telephone #

Outpatient Provider/Agency:____

Referring Provider:____Telephone:________________________

Current Medications: (If more than 10, attach copy of current MAR or Medication History sheet)

____ ____

____ ____

Allergies:____

****VERIFICATION of MEDICAID or PRIVATE INSURANCE BENEFITS for Partial Hospitalization Program (PHP) and access to medications is REQUIRED.**
Medicaid CIN # _____________________
Insurance Type: ____________________ID # ____________________________
Insurance Co. Phone # _____________________ Copay___________ Co-insurance ______________
Deductible (due at time of referral) _________________ Out Of Pocket Max____________________
Preauthorization Information: Authorization#________________ Dates Authorized____________
(Inpatient Referrals Only) Insurance Representative ____________________ _________________
Name Phone #

Current Symptoms:____

____

Patient's IQ (must be 70 or above):_____________

An Axis I Psychiatric Disorder that is the major focus of treatment meeting medical necessity criteria.
DX:____

Between the ages of 13 and 18, appropriate for the milieu and willing to attend: 8:00am to 2:00pm, Monday through Friday for a period of approximately three weeks. Child must be escorted by parent / legal guardian to intake appointment. Describe proposed plan of treatment: ____

____

A stable residence within safe daily commuting distance of APHP is required. Current Residence if other than own home:
____LOS:____________

Access to reliable transportation and telephone communication: (own car, cab, bus, rural transportation)
Type of transportation to be used:____

School Patient is Registered with:___________________________ Approve payment of tutor:____________

****DBT requires that a person NOT be under the influence of un-prescribed substances, therefore, 15 days of sobriety, co-occurring substance abuse treatment, and random urine drug screens are expected. Non-compliance may result in discharge from the program.**

Substance abuse history: (supported by toxicology reports, if available)
Date of last use:_____________________________ Substance(s) used:______________________________

No recent history of violence directed at others and a willingness to contract for safety and refrain from self-injurious behavior. Comments:____

____

Absence of any history of sexual aggression, victimizing or serious criminal behavior including domestic violence or stalking: Comments;____

____

Supports: Family, Friends, AA, NA, and any other supports, please indicate: ___________________

____

Parent / Legal Guardian and adolescent have been informed that APHP is a voluntary program and that admission to APHP is not a pre-requisite for hospital discharge.
Comments:____

Signature/Title:___________________ Print Name ____________________Date: _________Time_________

Approved by Document Control 2/2018