Rev. 4'17

PROGRAMS FOR PEOPLE, INC.

98 Lincoln Street Framingham, MA 01702-9627 Tel 508.879.3230 Fax 508.872.8724

REFERRAL TO DAY TREATMENT PROGRAM

PLEASE PRINT OR TYPE

Laura Hughes, PMHCNS-BC - Administrative Director
Ethan Harris, LICSW - Clinical Director

Date of Application:____/____/____

Referent (Name & License):____ Telephone # ______________________
Referent's Organization:____

I. IDENTIFYING INFORMATION

Applicant's Name:____ Telephone #________________________
Date of Birth:______________ Home Address:______________________________ ________________________
Street Town
Legal Sex (please check one)* __ Female __ Male

*While we recognize a number of genders / sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the legal name and sex listed on the insurance must be used for insurance billing and correspondence. If the applicant's preferred name and pronouns are different from those, please let us know: ____
____

Social Security Number:_____-_____-________ Cultural / Linguistic Background: ___________________________

Is this a hospital diversion? Yes ________ No________

HEALTH INSURANCE	Policy Number	Subscriber	If Private Insurance, Contact Person Name	Telephone #

SIGNIFICANT NON-PROFESSIONALS (Include members of applicant's immediate family):

Name	Relationship	Age	Address	Supportive to Applicant	No Contact with Applicant

Who of the above would be willing to accompany applicant to an intake meeting? ___________________________________

OUTPATIENT TREATMENT TEAM	NAME	TELEPHONE #
Current Therapist:		
Medicating Psychiatrist/Nurse:		
Case Manager:		
MRC Counselor:		
Primary Care Clinician:		

Applicant's response to this referral? ____
To what degree is applicant motivated to change? ____

II. DSM V DIAGNOSIS:

ICD-10 Code (if known)

Primary Diagnosis: ____
Additional BH/SA Diagnoses: ____
____

Date form received at FDH: ____ /____ /____ Date screened at FDH: ____ /____ /____

III. THE APPLICANT'S PRESENTING PROBLEMS:

A. Chief complaint: ______________________________

B. Current Stressors and/or precipitant: ______________________________

C. History of presenting problem: ______________________________

IV. SUICIDE / HOMOCIDE

A. Ideation: ______________________________
B. Plan / Intent / Means: ______________________________
C. History of Previous Attempts: ______________________________

V. MENTAL STATUS

A. Affect / Mood: ______________________________
B. Orientation: ______________________________
C. Memory: ______________________________
D. Intellect / Cognition: ______________________________
E. Perception / Sensation: ______________________________
F. Thought Process / Content: ______________________________
G. Hallucinations / Delusions: ______________________________

VI. FUNCTIONING

A. Ability to Perform Activities of Daily Living (ADL'S) ______________________________
B. Job / School: ______________________________
C. Sleep: ______________________________
E. Appetite: ______________________________

VII. PREVIOUS MENTAL HEALTH TREATMENT

Agency, Hospital, Therapist	Precipitant	Dates	Length of Stay (LOS)

VIII. SUBSTANCE ABUSE HISTORY

Name of Substance	Amount of Use	Frequency	Treatment	Date of Last Use

Does Applicant consider substance use a problem? Yes: __________ No: __________
What is applicant's commitment to sobriety: ______________________________
What is the plan to attain/maintain sobriety? ______________________________

IX: CURRENT MEDICATION(S) (Include medications for psychiatric and non-psychiatric condition)

Name of Drug	Dosage	Frequency
	Mg.	
	Mg.	
	Mg.	

X. NICOTINE USE

Does the client use nicotine? ____________________
If so, in what form? ____________________
How often (if cigarettes, how many)?____________________

XI. SIGNIFICANT MEDICAL HISTORY AND ALLERGIES

A. Pertinent medical history: ____________________
B. Allergies: ____________________

XII. FAMILY / DEVELOPMENTAL

Relationship	History of Mental Illness	History of Substance Abuse
Mother		
Father		
Sibling		
Other		

Applicant's history of abuse, neglect (domestic, sexual, physical, emotional) ____________________

Social History: ____________________

History of Military Service: ____________________

XIII. TREATMENT PLAN (In addition to day structure)

A. Focus / Goals: ____________________
B. Obstacles of Treatment: ____________________
C. Previous Treatment Progress / Goals Achieved: ____________________
D. Expected Response / Compliance to Treatment at Programs for People: ____________________
E. Special Circumstances:
Assaultive Behavior: ____________________
Involved in Court Action: ____________________
Does Client have Access to Weapons: ____________________
Legal Guardianship: ____________________
F. Estimated Length of Stay (ELOS): ____________________

How will the client get to and from Programs For People every day? ____________________

NOTE: We appreciate your taking the time to complete this form. We must have the above information prior to admission. This information may also be necessary for obtaining authorization for services, and for this reason we are required to obtain a "release" signed by the applicant prior to making the authorization call. Please use the attached form and submit it with this referral form. Thank you.

DO NOT EMAIL COMPLETED REFERRAL FORM. Please Fax (508-872-8724) Or Mail The Completed Form.

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DAY TREATMENT PROGRAM

Release of Information Agreement
for
INSURANCE PAYOR

I____, give my permission for Programs For People, Inc.
(applicant's name)

to give information regarding my case to my insurance payor _______________________________________
(name of insurance payor*)

as requested. I understand why the information is needed and am satisfied that the material will be considered confidential.

____
Signature of Applicant/Guardian

____
Signature of Referent

____
Date

____
Witness Name