Partial Hospitalization Program at Harrington Hospital

Referral Form

Phone: (508) 765-2248 | Fax: (508) 765-2197

Referred By: ______________________ Referral Date: __________

Referrer Phone #: __________ Referrer Email: ______________

Client Name:				Date of Birth:	
Client Phone #:		SS#:		HMH MR#:	
Client Address:					
Mode of Transport:					

All Referral Sources Must Attach the Following

- ☐ Face Sheet (with insurance information)
- ☐ Current Medication List
- ☐ Most Recent Assessment

Inpatient Programs Please Include

- ☐ History and Physical/Admission Note
- ☐ Recent MD Notes
- ☐ Discharge Information

Discharge Date (if inpatient):

Inpatient and Emergency Services Referrals Must Include Insurance Authorization

Insurance Plan:		Policy Number:	
Authorization #:		Days Authorized:	
Reviewer:		Review Date:	

	Provider / Agency Name	Phone
Psychiatrist		
Therapist		
PCP		
Suboxone/Methadone		
Case Manager		
Other		

Motivation: ☐ High ☐ Moderate ☐ Ambivalent

Primary Diagnosis Code:

Presenting Problem:

Treatment Goals: