Harrington
HEALTHCARE SYSTEM
Total Local Care

Co-Occurring Disorders Partial Hospitalization Program

Referral Form

Phone: (508) 949-8905 | Fax: (508) 943-2604

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		

Primary Diagnosis Code: Motivation: ☐ High ☐ Moderate ☐ Ambivalent

Presenting Problem:

Treatment Goals: