McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

3East Partial Hospital Program Referral Form

Please download this form before filling it out. Form can be returned by fax to **617.855.2832** or mail to:
McLean Hospital
3East Partial Hospital Program – Brinna Durney
115 Mill Street, Mail Stop 125
Belmont, MA 02478

Questions: Contact bdurney@partners.org
Please contact Brinna Durney for payment process information at 617.855.2820

Date of Application: _____ **Date of Interview:** _____

Name of Person Filling Out This Form: _____

Client Name:	Age Today:	DOB:
Address:	Client Email:	
Town:	Client's Cell #:	
Home Phone #:	Left or Right Handed? ☐ Left ☐ Right	

Parent/Guardian 1:	Parent/Guardian 2:
Address:	Address:
Home Phone #:	Home Phone #:
Work #:	Work #:
Cell #:	Cell #:
Email:	Email:

Note: the information below will not be used to contact anyone unless the required release forms provided at the time of admission have been filled out.

Therapist:	Therapist Address and Phone:
Psychiatrist/Psychiatric Medication Prescriber:	P/PMP Address and Phone:
Primary Care Provider:	PCP Address and Phone:
School Name/Grade:	School Address:
School Contact:	School Contact Phone:

Why are you interested in a 4-week day program and, specifically, one that teaches DBT (dialectical behavior therapy) skills? Please describe any current issues that you think can be addressed by DBT.

_____

_____

_____

_____

Please list ALL current medications including over the counter medications, nutritional supplements, vitamins, birth control, allergy meds, and acne meds.

Medication name	**Dose and times taken**	**Is medication being taken as prescribed?**	**Side effects from this medication**

Please list allergies to any medications (indicate none, if does not apply):

_____

_____

Please list previous psychiatric treatment/treaters (including hospitalizations, emergency room visits, programs, therapy) with approximate dates and reasons for treatment.

Name of program/treaters	**Dates**	**Reasons**

MEDICAL – Is there a history of (please describe if checked):

- ☐ Asthma: _____
- ☐ Diabetes: _____
- ☐ Operations/surgery: _____
- ☐ Medical hospitalizations: _____
- ☐ Developmental problems/concerns: _____
- ☐ Fractures/sprains: _____
- ☐ Head injury/concussion: _____
- ☐ Vomiting/GI concerns: _____
- ☐ Other: _____

CONCERNING BEHAVIORS – Is there a history of (please describe if checked):

- ☐ Self-injury: _____
- ☐ Suicidal ideation/statements/behaviors: _____
- ☐ Homicidal ideation/statements/behaviors: _____
- ☐ Stealing/fire setting: _____
- ☐ Legal problems/police involvement: _____
- ☐ High-risk sexual behaviors: _____
- ☐ Diet pills/laxative use: _____
- ☐ Excessive exercise: _____
- ☐ Purging: _____
- ☐ Concerns with eating/sleeping: _____
- ☐ Running away: _____
- ☐ Not following curfew: _____
- ☐ Concerns with electronics/computer time: _____
- ☐ Aggression: _____
- ☐ Isolating from friends or family: _____

TRAUMA – Have you or others in the family ever experienced (please describe if checked):

- ☐ Notable recent stressors/losses: _____
- ☐ Family DCF involvement: _____
- ☐ Natural disaster: _____
- ☐ Serious accident or injury: _____
- ☐ Combat or being in a combat zone: _____
- ☐ Sudden, life-threatening illness: _____
- ☐ Being attacked physically: _____
- ☐ Witnessing severe physical violence: _____
- ☐ Sexual abuse as a child or adolescent: _____
- ☐ Being a victim of a sexual or physical assault: _____
- ☐ Sudden death of a close friend or family member: _____
- ☐ Suicide of a close friend or family member: _____
- ☐ Traumatic invalidation (severe verbal or emotional abuse): _____
- ☐ Peer bullying: _____

If you have experienced any of the above traumas:

Did you notice a change in behavior immediately following this event?

Did you seek any professional help to talk about this event in the immediate aftermath?

Unrelated to any specific traumatic event:

Have you ever refused to engage in expected/typical activities such as school, sports, social events?

What was the reasoning around this refusal and how long did it take to resume the activity?

How much and what kind of support did you need to resume this activity?

Do you have any specific phobias or fears?

SCHOOL ISSUES – Is there a history of (please describe if checked):

☐ Having a change in their grades: _____
☐ Being suspended from school: _____
☐ Being held back in school: _____
☐ Learning disabilities: _____
☐ Having special education supports (504 or IEP): _____
☐ Having past educational or psychological testing: _____
☐ School absence/avoidance: _____
☐ Skipping school or leaving school: _____

SUBSTANCE USE:

Drug	(check)	Amount	Frequency	Date of last use
Alcohol	☐			
Cocaine	☐			
Heroin	☐			
Opiates	☐			
Marijuana	☐			
Stimulants	☐			

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3East Partial Hospital Program Commitment Agreements

In order for DBT to be effective, personal goals are identified so they can be targeted by treatment. We will help to clarify these goals and ask that patients commit to addressing these goals in treatment. Without established goals and a commitment to addressing them this program would not be an effective treatment choice.

Patient Agreements

- Patients understand that this program is designed to be at minimum 4 weeks long and agree to participate in the program for at least that length of time
- Patients will work with the therapist to define goals and will work on changing the target behaviors as agreed upon between patient and therapist
- Patients will complete group homework assignments and personal diary cards
- Patients will maintain the confidentiality and be respectful of peers attending the program
- Patients will be on time and attend all groups
- Patients will work to tolerate emotional discomfort
- Patients will ask for skills coaching
- Patients will not attend group under the influence of mind altering substances
- Patients will not smoke on campus unless they are A) under 18 and have the signed permission of their parents/guardian or B) are over 18
- Patients will not use or bring alcohol, cannabis products, illicit substances, or non-prescribed medications to the PHP program or to the McLean campus
- Patients will not use or bring prn medications to the PHP Program without permission of the PHP Medical Director
- Patients will not leave the campus proper during program hours unless accompanied by their parent/legal guardian or permission has been obtained from program staff

Treatment Provider Agreements

- Providers agree to make every reasonable effort to conduct competent and effective therapy
- Providers agree to obey standard ethical and professional guidelines
- Providers agree to be available to the patient for regular therapy sessions, phone consultations, and provide needed therapy back-up
- Providers agree to respect the integrity and rights of the client
- Providers agree to maintain confidentiality
- Providers agree to obtain consultation from the DBT team when necessary

Parent Agreements

- Parents will attend the first morning of the program to sign admission paperwork, remit payment, and participate in the psychiatric admission interview
- Parents will participate in family therapy sessions
- Parents will make every effort to attend parent group as our experience suggests that parent attendance is correlated with better results for the patient and family

Patient signature: _____ Date: _____

Provider signature: _____ Date: _____

Parent signature: _____ Date: _____

Parent signature: _____ Date: _____