McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

Adolescent Acute Residential Treatment Program

Inquiry for Admission: Residential and Partial Hospital Programs

Today's date: ____- ____- ____ **Inquiry rec'd by:** _______________

1. **What is your relationship to the patient? Form to be filled out by therapist/clinical unless none, then by parent.**
☐ Clinician, McLean ☐ Parent/Guardian ☐ Other (e.g. court, lawyer…): _____________________

☐ Referring provider, outside McLean: (facility): _____________________

2. **Patient Name**: ______________________________ **Age:**_______ **DOB:** ________ **Gender:** _____

Address: ______________________City: ___________________ State: __________ Zip: ________

Parents name:___________________________________ **Phone:** _______________________________

How soon does patient want to be admitted? ________ **Anticipated admit date:**_________

DCF Involvement? ☐ No ☐ Yes, case worker name: ___________________ **Custody status**: ___

Current living situation? __________________ **Where will they live after 2-week stay?**___________________

3. Please share <u>your</u> contact information
Name: ____ Daytime phone: ___________________

Address: _______________________State/ Country: _______________ Zip: _____________

Cell: ___________________ Fax: ________________ Email: _______________________________

If you are Clinician, are you: ☐ MD ☐ PhD ☐ LICSW ☐ Other:______________________

Organization or Facility Name: ___________________________ Date Admitted: ___________________

4. Level of care you seek: ☐ Residential –acute ☐ Residential – acute dual diagnosis
☐ Partial Hospital Program (coed, no substance use)

5. Financial feasibility: Does patient **plan** to use insurance to cover care? ☐ No ☐ Yes

If No*, will they pay directly?* ____ **Please provide insurance information:**

Primary Insurance Name: _______________________ **ID#:**_____________ **Phone**: ______________

Subscriber name: ______________________________ **Subscriber DOB**: __________

Secondary Insurance Name: _____________________ **ID#:**_________________ **Phone**: _______________

Subscriber name: ______________________________ **Subscriber DOB**: _____________

6. Patient Background
Student? ☐ No ☐ Yes, School name: ______________________________ **Current grade:**______

Please describe current school performance (motivated, attendance, interests…) _________________________

____

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Cognitive Status ☐ Average ☐ Below average: *Describe*: ______________________________

Learning Disability: ☐ None ☐ Yes *If yes, specify*: ______________________________

Developmental Disorder: ☐ None ☐ Yes *If yes, specify*: ______________________________

IEP or SPED issues: ☐ None ☐ Yes *If yes, specify*: ______________________________

Motivation/willingness for residential or partial hospital treatment: ☐ Low ☐ Moderate ☐ High

Family's willingness to participate in care: ☐ Low ☐ Moderate ☐ High

7. How did you hear about our program? Please be as specific as you can.

☐ Internet: __________________ ☐ Word of mouth ☐ Reputation
☐ I've referred here in the past ☐ At a conference ☐ From a colleague: ______________________
☐ Other: ____

8. HISTORY

Please share history and current clinical update:

____

____

____

____

What are the acute problems to be addressed in ART?

____

____

____

What are patient's goals for treatment?

____

____

____

Psychiatric Diagnoses (please describe): ______________________________

____

____

Previous inpatient and/or detox hospitalizations, psychiatric treatment programs:

Date: ________ Location: ____________________________ Reasons: ______________________________

____

Date: ________ Location: ____________________________ Reasons: ______________________________

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Date:________ Location: ________________________ Reasons: ____________________________________

Current Medications and dosages:

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

Current Substance Use History

Smoker: ☐ Never ☐ Past ☐ Current: *If yes:* Willing to use patch? ☐ No ☐ Yes

Willing to consent to being in a non-smoking program, and no smoking on any passes? ☐ No ☐ Yes

Date of longest sobriety: ____

Below chart MUST be filled in with amounts and frequency for form to be complete

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

1. **C** Have you ever ridden in a ***CAR*** driven by someone (including yourself) who was ''high'' or had been using alcohol or drugs? ☐ Yes ☐ No
2. **R** Do you ever use alcohol or drugs to ***RELAX***, feel better about yourself, or fit in? ☐ Yes ☐ No
3. **A** Do you ever use alcohol or drugs while you are ***ALONE***? ☐ Yes ☐ No
4. **F** Do you ever ***FORGET*** things you did while using alcohol or drugs? ☐ Yes ☐ No
5. **F** Do your family or ***FRIENDS*** ever tell you that you should cut down on your drinking or drug use? ☐ Yes ☐ No
6. **T** Have you ever gotten into ***TROUBLE*** while you were using alcohol or drugs? ☐ Yes ☐ No

Medical conditions: ____

____

Asthma: No ☐ Yes ☐ ***If yes, please provide* asthma action plan *if available*

Diabetes: No ☐ Yes ☐ ***If yes, please request* diabetes pre-screen *form*

Seizure Disorder: No ☐ Yes ☐ ***If yes, please request* seizure disorder pre-screen *form*

Allergies: ____

Safety

History of elopement ☐ No ☐ Yes: ______________________________

If yes, willing to contract to refrain from these behaviors in unlocked residential setting? No ☐ Yes ☐

Present Suicide ideation ☐ No ☐ Yes: ______________________________

If yes, willing to contract to refrain from these behaviors in unlocked residential setting? No ☐ Yes ☐

Self-harm ☐ No ☐ Yes: ______________________

If yes, willing to contract to refrain from these behaviors in unlocked residential setting? No ☐ Yes ☐

Present eating disorder ☐ No ☐ Yes; severity: ______________________

If yes, willing to contract to refrain from these behaviors in unlocked residential setting? No ☐ Yes ☐

Anger/Aggression/Violence ☐ No ☐ Yes: ______________________

Past suicide attempts ☐ No ☐ Yes: ______________________

Oppositional Behavior ☐ No ☐ Yes: ______________________

Fire-setting hx ☐ No ☐ Yes: ______________________

Recent restraint (in past week) ☐ No ☐ Yes: ______________________

Legal Problems: ☐ No ☐ Yes Court Date: ☐ No ☐ Yes

Charges Pending: ☐ No ☐ Yes Restraining Order: ☐ No ☐ Yes

Details: ______________________

Current outpatient treatment team:

Pharmacologist: ______________________ Phone #: ____________

Therapist: ______________________ Phone #: ____________

PCP: ______________________ Phone #: ____________

Other: ______________________ Phone #: ____________

Note: Please be sure to bring all current medications or have prescriptions filled at local pharmacy

Updated 04/11/18