McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

Belmont Adolescent Partial Hospital Program Inquiry for Admission

Please download this form before filling it out. Please type or print clearly.

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

***If No**, will they pay directly?* _____

5. 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…) _____

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 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 the partial program?

_____

_____

_____

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: _____

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 ***C*AR** 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 ***R*ELAX**, feel better about yourself, or fit in? ☐ Yes ☐ No
3. **A** Do you ever use alcohol or drugs while you are ***A*LONE**? ☐ Yes ☐ No
4. **F** Do you ever ***F*ORGET** things you did while using alcohol or drugs? ☐ Yes ☐ No
5. **F** Do your family or ***F*RIENDS** ever tell you that you should cut down on your drinking or drug use? ☐ Yes ☐ No
6. **T** Have you ever gotten into ***T*ROUBLE** 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 a partial setting? No ☐ Yes ☐

Present Suicide ideation ☐ No ☐ Yes: _____

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

Self-harm ☐ No ☐ Yes: _____

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

Present eating disorder ☐ No ☐ Yes; severity: _____

If yes, willing to contract to refrain from these behaviors in a partial 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 #: _____