McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

McLean SouthEast Adult Partial Hospital Program Referral Form

Please download this form before completing. Completed forms can be submitted via fax to **774.419.1044,** Attn: Mark Longsjo, LICSW, Program Director.

The MSE Partial Hospital Program utilizes cognitive behavior therapy to treat individuals struggling with mood disorders, such as depression and anxiety.

Please note that we do not treat active symptoms of psychosis or substance misuse. The program is voluntary and patients must agree to abstain from using alcohol and drugs for the duration of the program.

Date of Referral: _____

Patient Name: _____DOB: _____

Address:_____ City/State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Occupation: _____ Current living situation: _____ Transportation to PHP: _____

Referred By: _____ Phone: _____

Insurance company: _____ Phone to verify benefits: _____

Insurance ID #: _____ Group #: _____

Subscriber: _____ DOB: _____

Insurance company: _____ Phone to verify benefits: _____

Insurance ID #: _____ Group #: _____

Subscriber: _____ DOB: _____

Why does the patient currently need a partial hospital level of care?:

_____

_____

_____

Goals for referral to MSE Partial Hospital Program:

_____

_____

_____

Psychiatric diagnoses:

_____

_____

Previous inpatient and/or detox hospitalizations. Specify dates, facilities, and reason:

_____

_____

_____

_____

Substance Use History

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

Longest period of sobriety and when: _____

History of an eating disorder: ☐ Yes ☐ No If yes: Current height: _____ Weight: _____

History of suicide attempt(s): specify dates and means:

_____

___ _____

History of self-injurious behavior. Specify frequency, means, and occurrence:

_____

History of trauma: _____

Current safety status: Suicidal ☐ Yes ☐ No Homicidal: ☐ Yes ☐ No

If yes, please explain: _____

Current Medications and dosages:

_____

_____

_____

Last blood level results for medications if indicated: _____

Medical conditions:

_____

_____

_____

Allergies: _____

Current outpatient treatment team:

Therapist: _____ Phone: _____

Pharmacologist: _____ Phone: _____

PCP: _____ Phone: _____

Other: _____ Phone: _____

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

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

If yes, please explain: _____

_____ _____

Signature of person filling out form Print Name

Please forward copies of the following information: Admission Note; History/Physical and Psych Testing if available.

Completed forms can be submitted via fax to **774.419.1044,** Attn: Mark Longsjo, LICSW, Program Director. With any questions, call 774.419.1040.