McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

McLEAN HOSPITAL SOUTHEAST
ADOLESCENT PARTIAL PROGRAM
REFERRAL FORM

Referral Date: _____

23 Isaac Street, Middleborough, MA 02346
Attn: Joyce Velt, LICSW/Program Director
Phone: 774-419-1141 Fax: 774-419-1090

NAME: _____ **DOB:** _____

Address: _____

Zip Code: _____

Parents' Names: _____

Tel. #: _____ **Cell Phone #:** _____

Referred By: _____
Relationship: _____
Agency/Facility (if applicable)
_____

Phone #: _____

Insurance Co.: _____
ID #: _____
***Subscriber:** _____ **Subscriber DOB:** _____

Secondary Insurance Co.:_____
ID#: _____
***Subscriber:** _____ **Subscriber DOB:** _____

Current clinical update for referral to partial hospital:
_____
_____
_____
_____
_____

Goals for referral to partial hospital:
_____
_____
_____
_____

Previous inpatient, CBAT or Outpatient Treatment. Specify dates, facilities & reason:

_____

_____

_____

Substance Abuse:	**Amount:**	**Frequency:**	**Date of last use:**

History:
Drug: _____
_____
_____
Alcohol: _____
Marijuana: _____
Other: _____

Current medications and Dosages:

_____
_____
_____

Medical Conditions:

_____
_____
_____

Current Outpatient Team:

Pharmacologist: _____

Therapist: _____

CBHI Services: _____

DMH: _____

DCF: _____

Other: _____

Diagnosis:

I: _____

II: _____

III: _____

IV: _____

V: _____

School:_____

Grade: _____

Accommodations: _____

Guidance/Adjustment Counselor: _____

IEP/504: _____

CRA: _____

Current living situation:

_____

Transportation to program:

_____