

Hill Center for Women Referral Form

To be completed by clinician only.

All information is required in order to process this application.

Form Submission Options

1. **Fax**

Download this document, which is a fillable PDF that you can type into and save. Complete and print pages 2-5. Fax to us, along with any supporting clinical notes/documentation, at **617.855.3738**.

2. **Partners HealthCare HIPAA-Compliant Adobe Sign Portal**

Click on the following link to submit your referral electronically. Please note that this submission method requires you to complete the referral in one sitting, so you may wish to review the form and collect information in advance.

Click here: [Adobe Sign Portal](#)

3. **Postal mail**

Download this document, which is a fillable PDF that you can type into and save. Complete and print pages 2-5. Mail, along with supporting clinical documents, via postal mail to:

McLean Hospital
Hill Center for Women, ATTN: Referrals
115 Mill Street
Belmont, MA 02478

Note: Form submission via fax or postal mail may result in a delay in response.

With any questions, please call us at 617.855.2595.

Please provide any notable personality characteristics:

Substance Use History

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

Longest period of sobriety & when: _____

History of an eating disorder: Yes _____ No _____ Current eating disorder: Yes _____ No _____

If Yes to either:

Binging: Yes _____ No _____ Purging: Yes _____ No _____ Restricting: Yes _____ No _____

Current medications and dosages:

Medical conditions:

Allergies: _____

For all conditions listed above please attach a letter of medical clearance from PCP listing medical issues, symptom presentation, past treatment, continued treatment, and recent bloodwork or labs.

Current outpatient treatment team:

Pharmacologist: _____ Phone #: _____

Therapist: _____ Phone #: _____

PCP: _____ Phone #: _____

Will the current outpatient treatment team be continuing to provide aftercare following treatment at The Hill Center?

Yes _____ No _____

Legal Issues:

Yes No

Yes No

Legal Problems:

Court Date:

Charges Pending:

Restraining Order:

Please explain: _____

All previous inpatient and/or detox hospitalization, including, but not limited to, any McLean admissions. Specify dates, facilities, and reason: _____

History of suicide attempt(s). Specify dates and means: _____

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

History of trauma: _____

Current safety status:	Plan:	Intent:	Contract for safety:
Suicidal ideation: Yes___ No___	Yes___ No___	Yes___ No___	Yes___ No___
Homicidal ideation: Yes___ No___	Yes___ No___	Yes___ No___	Yes___ No___
Self-injurious behavior: Yes___ No___	Yes___ No___	Yes___ No___	Yes___ No___

How did you hear about our program?

Internet: specify search engine: _____ Conference: specify (i.e. ISSTD) _____

Printed Ad: specify _____ Other: specify _____

Please fill out form completely. Incomplete forms will delay the admission process.

Thank you for referring your client to the Hill Center for Women at McLean Hospital. Once your client has completed an intake with the clinical staff at the Hill Center, you will receive a phone call from the clinician doing the intake.

Printed name of referring clinician

Signature of referring clinician Date

Page 5 must be completed by patient and submitted at time of referral.

See page 1 for submission instructions.

Hill Center for Women Referral Form

To be completed by patient.

Name: _____

Date of Birth: _____

Thank you for applying to McLean Hospital's Hill Center for Women. Your investment in treatment is integral to your therapeutic success in the program.

Please identify, in your own words, the top four goals that you want to focus on during your 2 week stay at the Hill Center.

1. _____

2. _____

3. _____

4. _____

I authorize members of the Hill Center for Women staff to speak with my insurance company and treatment team, as listed in this referral, in service of my application to the program.

Printed Name

Signature

Date