Hill Center for Women Referral Form

To be completed by clinician only.

Please download this form before filling it out. All information is required in order to process this application. Submission instructions are located at the bottom of page 3.

Date of Referral: _______________

Day Treatment Residential

Name: ____ Alias: ______________________ DOB: _____________

Address: ____

Street Town State Zip Code

Phone #: ___________________________________ Cell Phone #: ____

Email address: ____

Occupation: ____ Current Height: ____________Weight: _____________

Current living situation: ____

Transportation to program: ____

Referring clinician: _____________________________ Facility: _______________________ Phone #: ____________________

Insurance: __________________________________ ID #: ____

Subscriber: _____________________________ DOB: _________ Insurance phone: ___________________________________

Secondary insurance: ______________________________ ID #: ____

Subscriber: ____________________________ DOB: _________ Insurance phone: ___________________________________

Current clinical update for referral to the Hill Center: ____

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Goals for referral to the Hill Center: ____

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Please provide a complete diagnosis:

____

Pyschosocial stressors:

____

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: ____

____

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____

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 4 must be completed by patient and faxed at time of referral.

Fax completed form to our Admissions Coordinator at **617.855.3738.** Please call to verify receipt of fax at **617.855.2595.**

Please do not fax medical records.

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

Fax completed form to our Admissions Coordinator at
617.855.3738. Please call to verify receipt of fax at **617.855.2595.**