Referral for Spring Harbor Developmental Disorders Partial Hospitalization Program

Date: ________________
Referral Source Name/Agency: ____
Referral Source Phone Number: _________________ Email Address: ___________________
Paperwork completed by: ____

Patient Name: __________________________________ DOB:___________ Age:___________
Preferred names they go by: ____
SSN: ______-_____-_______ Sex: M ☐F ☐ Non-Binary ☐ Height: _____ Weight: ______
Home Address: ____
Home Phone #:_______________________Alternative phone #:________________________
Living with (names):____

Guardian (relationship):____
Does the patient have Mainecare? Yes ☐ No ☐ Policy #: __________________________
Does the patient have other insurance? Yes ☐ No ☐ Name of company: _______________
Policy #:________________ Guardian Phone # (if different from above)_________________

School Name: ___________________________________ Grade: ______________________
Sending School district (if different from attending): ___________________________________
Does patient have a current IEP and receive Special Education Services? Yes ☐ No ☐

Interpreter / Accommodations needed? Yes ☐ No ☐ if yes, please explain:_____________
____

Clinical Information:
Reason(s) for hospitalization: ____
____
What are your goals for hospitalization?____
____
Have there been any recent changes/losses in the patient's life? Yes ☐ No ☐
If yes please describe:____
____
Prior psychiatric hospitalization? Yes ☐ No ☐ If yes, where and when? ________________
____

Current Providers:
Psychiatrist:____ Phone:_________________
Pediatrician/Family Physician: ___________________________ Phone:_________________
Developmental Behavioral Pediatrician: ___________________ Phone:_________________
Therapist:____ Phone:_________________
Community Case Manager: ________________________________ Phone:_________________
In-Home Supports:______________________________________ Phone: _________________

List of *current medications*, dosage and time:

1.____________________________________ 4. __________________________________
2.____________________________________ 5.___________________________________
3.____________________________________ 6. __________________________________

Any current over the counter or herbal remedies? Please list: ________________________
____

Allergies to medication? Yes ☐ No ☐ If yes, please list: ___________________________
Other allergies? Yes ☐ No ☐ If yes, please list: _________________________________

Psychiatric Diagnoses:
____
____

Is there a history of DRO (drug resistant organisms) such as MRSA or VRE? Yes ☐ No ☐

Seizure Disorder? Yes ☐ No ☐ If yes, type: ____________; Date of last seizure: ________

Other medical conditions

1. ____
2. ____
3. ____

Patient's communication could be best described as: (please select)
Verbal ☐ Limited Verbal ☐ Non-Verbal ☐

Behavioral Concerns:
Does the patient engage in behaviors that may result in physical harm to themselves or others? Yes ☐ No ☐ if yes, please describe: _____________________________________
How often? ____________ Directed toward whom? _______________________________
When was the most recent time? ____
Has patient ever required a physical restraint? Yes ☐ No ☐ If yes, please describe:
____

Current or past suicidal ideation: Yes ☐ No ☐ If yes, please describe: ________________
____

Any history of **inappropriate sexual behavior**? Yes ☐ No ☐ If yes, please describe:
____

Any history of **bolting or elopement**? Yes ☐ No ☐

Please send the following information where applicable: IEP, psychological evaluations, psychiatric notes, occupational therapy evaluations, speech/language therapy evaluations.

All information should be faxed to the Partial Hospitalization Program at 207-661-6089. Please call 207-661-6347 with any questions.