



**METROWEST MEDICAL CENTER**

Framingham Union Hospital • Leonard Morse Hospital

## Partial Hospital Program (PHP/IOP)

67 Union St. Natick, MA 01760

### Referral Form

Phone: 508-650-7380 Fax: 508-650-7128

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| CLIENT INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                      |                                                                                          |           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|------------------------------------------------------------------------------------------|-----------|
| Client Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                      |                                                                                          | Date:     |
| DOB:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | SSN#:                                | Client Phone #:                                                                          |           |
| Address:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                      | City:                                                                                    | Zip Code: |
| Presenting Issue:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                      |                                                                                          |           |
| Level of Care:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                      | Start Date:                                                                              |           |
| Currently Inpatient: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Unit:                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                      | Phone #:                                                                                 | D/C Date: |
| Mode of Transportation:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                      | Emergency Contact Information:                                                           |           |
| INSURANCE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                      |                                                                                          |           |
| Insurance:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                      | Policy #                                                                                 |           |
| Subscriber:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                      | Policy Managed by:                                                                       |           |
| Phone #:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                      | Tufts Cap? <input type="checkbox"/> Yes <input type="checkbox"/> No                      |           |
| *INPATIENT and EMERGENCY SERVICES Please Try To Include Insurance Authorization                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                      |                                                                                          |           |
| Authorization #:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                      | Days Authorized:                                                                         |           |
| Review Date:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Review with (name of ins. Reviewer): |                                                                                          |           |
| REFERRAL SOURCE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                      |                                                                                          |           |
| Referring Organization:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                      | Referral Phone:                                                                          |           |
| Contact Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                      | Referral E-mail:                                                                         |           |
| Provider/Agency                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Phone Number                         |                                                                                          |           |
| Psychiatrist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                      |                                                                                          |           |
| Therapist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                      |                                                                                          |           |
| PCP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                      |                                                                                          |           |
| Suboxone/Methadone                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                      |                                                                                          |           |
| Case Manager                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                      |                                                                                          |           |
| Other                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                      |                                                                                          |           |
| Treatment Goals:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                      |                                                                                          |           |
| <p><b>*All Referral Sources Attach the Following:</b></p> <p><input type="checkbox"/> Face Sheet (with insurance information) <input type="checkbox"/> Current Medication List</p> <p><input type="checkbox"/> Most Recent Assessment</p> <p><b>Inpatient Programs Please Include</b></p> <p><input type="checkbox"/> History and Physical/Admission Note <input type="checkbox"/> Recent MD Notes <input type="checkbox"/> Social Work Assessment</p> <p><input type="checkbox"/> Discharge Information Discharge Date (if inpatient):</p> |                                      |                                                                                          |           |
| OFFICE USE ONLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                      |                                                                                          |           |
| Appt. Time & Date:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                      | Appt Kept: <input type="checkbox"/> Yes <input type="checkbox"/> No,                     |           |
| Reminder Call, Date:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                      | Reschedule <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Date & Time: |           |