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| --- | --- |
| 1900 Randolph Road ▪ Suite 402 ▪ Metroview Building  Charlotte, NC 28207  Phone: 704.384.7001 | 13815 Professional Center Drive ▪ Suite 200  Huntersville, NC 28078  Phone:704.384.1370 |

**Adolescent Partial Hospitalization Program**

**Referral Form Todays Date:** Click to add

**Adolescents’s Name:** Legal Name **Preferred Name:** If applicable

**DOB:** MM/DD/YY **Age:** ## **Gender:** Type in **MRN:** #######

**PHP Location:**   Charlotte  Huntersville  No Preference

**Reason for Referral:** Please specify

**Does/Has the adolescent…**

* **Have a current psychiatric diagnosis?** No  Yes: Please specify
* **Ever exhibited any sexually acting out behaviors?** No  Yes: Please specify
* **Ever exhibited any significant aggression?**  No  Yes: Please specify
* **Have a primary substance abuse problem?**  No  Yes: Please specify
* **Have significant or active eating disorder?**  No  Yes: Please specify
* **Have a medical condition that prevents beneficial utilization of the program?**  No  Yes: Please specify

**Is the adolescent a danger to self or others?**  No  Yes: Please specify

*School Information*

**School Attending**: Please specify **Grade:** Please specify

**Academic/School Strengths:** Please specify

**Academic/School Needs:**  Please specify

**Adolescent has an active**:  **504**  **IEP**  **N/A**

*Participation: \*to be answered by parent/legal guardian\**

**Are you willing/able to…**

* **Bring your adolescent to and from PHP every Monday-Friday 8:00am to 2:30pm?**  Yes  No
* **Participate in weekly family meetings?**  Yes  No
* **Commit to implementing changes recommended at home or in the community?**  Yes  No
* **Provide daily written feedback about your adolescent’s progress at home?**  Yes  No

*Physician/Psychiatrist*

**Does the adolescent…**

* **Have an outpatient Psychiatrist?**  No  Yes

Name/number: Click here to enter text. Next appointment: MM/DD

* **Have an outpatient therapist?**  No  Yes

Name/number: Click here to enter text. Next appointment: MM/DD

* **Have a Primary Care Physician?**  No  Yes

Name/number: Click here to enter text.

* **Take medications as prescribed?**  N/A  No  Yes

**What medications and dosages are currently prescribed to the adolescent?** Click here to enter text.

*Family*

**Currently Living with:** BiologicalParent(s)  Legal GuardianRelative  Foster Family

Other: Click here to enter text.

**Has the adolescent been adopted?** No Yes, date: MM/DD/YY

**Have parental rights been terminated? Mother:**  No  Yes, date: MM/DD/YY

**Father:**   No  Yes, date: MM/DD/YY

**Parent/Guardian:** Click here to enter text.

**Address:** Street

City, State, Zip

**Phone:** (###) ###-####

**Email:** Click here to enter text.

**Parent/Guardian:** Click here to enter text.

**Address:** Street

City, State, Zip

**Phone:** (###) ###-####

**Email:** Click here to enter text.

*Primary Insurance Information*

**Is the Adolescent insured?**  No  Yes

**Policyholder’s Name**: Click here to enter text. **DOB**: MM/DD/YY

**Insurance Carrier Name**: Click here to enter text. **Policy Number**: Click here to enter text.

*Referral Source*

**Name:** Click here to enter text. **Phone Number**: (###) ###-####

***\*Please remember to attach insurance card to this Referral Form and fax completed form to 704.316.9672 or***

***email to*** [***AdolescentPHPprogram@novanthealth.org\****](mailto:AdolescentPHPprogram@novanthealth.org*)

**NHPMC BH Adolescent Partial Hospitalization Program**

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