|  |  |
| --- | --- |
| 1900 Randolph Road ▪ Suite 402 ▪ Metroview BuildingCharlotte, NC 28207Phone: 704.384.7001  | 13815 Professional Center Drive ▪ Suite 200 Huntersville, NC 28078Phone: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 Guardian[ ] Relative [ ]  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\****

**NHPMC BH Adolescent Partial Hospitalization Program**

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