Penn Psychiatric Center
Partial Hospitalization Program
Referral Form

Client Name: _____ DOB: _____ Age: _____

Address: _____ City: _____ State: _____ County: _____

Phone: _____ Email: _____

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

THIS SECTION TO BE COMPLETED BY THE CLINICIAN WHO IS REFERRING THE CLIENT

Referring Agency: _____

Referring Clinician: _____ Phone: _____

Date of client's most recent psychiatric evaluation: _____ Completed by: _____

Date of client's most recent hospitalization/ residential treatment: _____

Name of facility of most recent hospitalization/ residential treatment: _____

Primary Diagnosis: _____ ICD10 Code: _____

Secondary Diagnosis: _____ ICD10 Code: _____

Check symptoms and write in number or occurrences in past 12 months:

☐ Restricting _____ ☐ Purging: _____ ☐ Bingeing: _____ ☐ Excercise: _____

☐ Use of weight loss supplements: _____

Additional information (suicide attempts, self-harm, drug & alcohol, etc: _____

_____

_____

THE FOLLOWING DOCUMENTATION MUST BE ATTATCHED

☐ Weight & Height (within last 72 hours) ☐ Vitals (within last 72 hours) ☐ Labs (within last 72 hours)

☐ EKG ☐ Urine Analysis (pregnancy screening/ D&A) ☐ List of current medications and dosage

IF AVAILABLE, PLEASE ALSO INCLUDE

☐ Meal Plan & Completion Percentages ☐ History/ Psychosocial

Client Signature: _____ Date: _____

Referring Clinician Signature: _____ Date: _____

Please complete the referral form in detail and fax to: 610-917-2360. Attn: Program Administrator.
Questions about how to complete this form? Call the Program Administrator at (610) 917-2200 ext 223
Completed referral forms will be reviewed by the PHP team for eligibility and consideration.
An intake appt. will be scheduled as soon as a spot becomes available.