Bournewood Dedham Center

A Division of BOURNEWOOD Health Systems

Date of Referral:

Referral to: ❑ Dedham MH PHP: (p) 617-676-3585

(Efax) 857-233-0166

Requested Start Date:

Patient Name: _____ Phone:_____DOB:_____ Gender:_____

Address: _____

Primary Insurance: _____ Policy #:_____ Secondary Insurance:_____ Policy #:_____

To Be Filled Out by Referral Source:

Referral Source: _____Phone: _____

Reason for referral: _____

_____

_____

_____

Relevant psychiatric or addiction history: _____

_____

_____

Is the patient able to participate in groups and actively participate in discharge planning? Please describe:

_____

What is the patient's current level of motivation for participating in the Bournewood program?

_____

Current living situation: _____

Able to commute to the program by: ❑Car ❑Public transport ❑Other_____

Legal Issues? _____ Sex offender? Y or N_____ Eating D/O?_____

Current Medication: _____

Diagnosis/ICD 10: _____

PCP: _____ Phone: _____

Therapist: _____ Phone: _____ Prescriber: _____ Phone:_____

Aftercare post PHP: Please list after care referrals made:

1._____ 2._____

Goals for PHP:

1._____ 2._____

Please attach: ❑ Biopsychosocial ❑ List of medications ❑ recent notes ❑ psych assessment

Referral Source Signature: _____ Date:_____

To Be Filled Out by Patient:

Please describe any past treatments and outcomes (i.e psychiatric inpatient, detoxes, MAT, outpatient counseling, etc).

_____

_____

_____

What is your current living situation?

_____

_____

What is your transportation to PHP?_____

If accepted to the Bournewood program, what do you hope to get out of the program and what is your aftercare plan post discharge?

_____

_____

_____

Who is your support system?

_____

1. Have you traveled outside of the United States in the past 3 months. If yes, where did you go?
2. Have you had a fever in the last 7 days?

Patient Signature:_____Date:_____

For office use only: Accepted: _____ Yes _____ No _____ Pending (incomplete referral)

Date/Time of Intake: _____ Canc/Rescheduled Date: _____

❑ Patient attended scheduled intake ❑ Patient called to cancel ❑ Patient did not attend scheduled intake

Actions Taken: ❑ Call placed to patient ❑ Call placed to emergency contact ❑ Notified referring person

❑ Reviewed case with:_____ Notes: _____

Signature:_____ Date:_____ Time:

*Do Not File In Medical Record