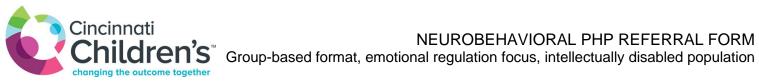


NEUROBEHAVIORAL PHP REFERRAL FORM

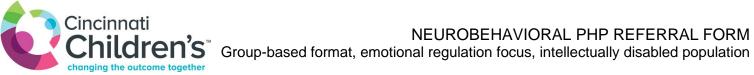
dren's Group-based format, emotional regulation focus, intellectually disabled population

Please complete this document in its entirety & provide enough information to support need for partial hospitalization admission. Please fax completed form to (513) 803-8173 & email to NBPHP@cchmc.org

REFERRING PROVIDER					
Name: Agency:					
Specialty: Phone:					
How long have you seen the patient? Last Appointment:					
Has patient displayed aggression in clinic visits? □No □Yes If yes, describe:					
PATIENT INFORMATION					
Today's Date:/CCHMC MR#(if available) Sex: □Female □Male					
Child's Full Legal Name:					
Date of Birth:/ Home Phone: Alt Phone:					
Parent/Caregiver A's full name:					
Parent/Caregiver B's full name:					
Guardianship: ☐ Biological Parent(s) ☐ Other					
(Please specify) Custody (if parents are divorced/separated): Joint Sole (Mother) Sole (Father) Other:					
(Please specify					
Mailing address:Street					
City State Zip Country					
REASON FOR REQUEST					
Reason for request/Specific question(s) to be answered:					
1					
2					
History / Symptoms:					
PATIENT MEDICAL AND DEVELOPMENTAL HISTORY					
Diagnoses: □Autism Spectrum Disorder □ADHD □Intellectual Disability(full scale IQ)					
Please include records of testing or diagnostic confirmation if available					
List all additional diagnoses:					



At what age(s), did s	he/he receive the	diagnoses?			
Current medical cond	cerns: □No □Yes	s If yes, describe:			
Current Language:	□Nonverbal □Pri	marily uses AAC □Pri	marily verbal communic	cation	
Current Educational	or other placemen	r nt: □At home □Day pr	ogram □Independent J	lob* □School, Grade	
	•				
Does patient have ar	n: □Individualized	Education Plan (IEP)	□504 Plan?		
Problems with school	ol? □No □Yes l	f yes, describe:			
Primary Care Physician Name:					
			Weight:		
<u>Current</u> medications	s, vitamins, supple	ments (include name, o	dose, frequency and ler	ngth of use):	
Name	Dose	Frequency	Indication	Length of use	
Relevant lab results	(please include da	ates):			
Past medications, vit	tamins, supplemei	nts (include name, dos	e, dates taken, effective	eness, side effects):	
Name	Dose	When taken	Effectiveness	Side effects	
Current Behavioral Health Provider:					
Past Behavioral Health Provider					
			Dates:	Phone:	
History of inpatient, r	esidential or partia	al hospital program adr	missions: □No □Yes		
Dates:	Na	me of Hospital/Prograr	n:		



Dates:Name of Hospital/Pro	Name of Hospital/Program:				
Is the patient currently a victim of physical/sexual/emotional abuse? □No □Yes If yes, describe:					
Does patient have a history of physical/sexual/emotional abuse? □No □Yes If yes, describe:					
Current legal charges: □No □Yes If yes, describe:					
Past legal charges: □No □Yes If yes, describe:					
CURRENT SERVICES					
Please indicate any waiver services patient receives					
For Ohio patients—enrolled in OhioRISE? No Yes					
Current insurance coverage (including copy of card will facilitate review)					
Please select services that patient currently rece	eives				
☐ Speech/language therapy/communication services	☐ Audiology services for hearing problems				
☐ Psychological/mental health or counseling	☐ Physical therapy				
☐ Social work services	☐ Occupational therapy				
☐ Life skills therapy/ training	☐ Orientation and mobility services				
☐ Tutor	☐ Respite Care				
☐ Transportation because of his or her special needs					
☐ Nursing Care	☐ Reader or interpreter, including sign language				
☐ Assistive technology services/devices, such as help getting/using any kind of equipment that helps people with a disability, such as a tape recorder or reading machine					
☐ Career counseling, help in finding a job, training in jo					
□ Personal assistant or an in-the-home or in-the-classroom aide					
Other Comments lleaves lComments					
Other Comments/Issues/Concerns:					