NEUROBEHAVIORAL PHP REFERRAL FORM
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 she/he receive the diagnoses? _____

_____

Current medical concerns: ☐No ☐Yes If yes, describe: _____

Current Language: ☐Nonverbal ☐Primarily uses AAC ☐Primarily verbal communication

Current Educational or other placement: ☐At home ☐Day program ☐Independent Job* ☐School, Grade ____

☐Supported Job* ☐Other _____ What school does patient attend? _____

Does patient have an: ☐Individualized Education Plan (IEP) ☐504 Plan?

Problems with school? ☐No ☐Yes If yes, describe: _____

_____

Primary Care Physician Name: _____Phone:_____

Allergies: ☐No ☐Yes If yes, describe: _____ Weight: _____ Height: _____

Current medications, vitamins, supplements (include name, dose, frequency and length of use):

Name	Dose	Frequency	Indication	Length of use

Relevant lab results (please include dates):_____

_____

Past medications, vitamins, supplements (include name, dose, dates taken, effectiveness, side effects):

Name	Dose	When taken	Effectiveness	Side effects

Current Behavioral Health Provider: _____Phone: _____

Past Behavioral Health Provider _____ Dates: _____ Phone: _____

_____ Dates: _____ Phone: _____

History of inpatient, residential or partial hospital program admissions: ☐No ☐Yes

Dates:_____Name of Hospital/Program:_____

Dates:_____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 receives

☐ Speech/language therapy/communication services
☐ Psychological/mental health or counseling
☐ Social work services
☐ Life skills therapy/ training
☐ Tutor
☐ Transportation because of his or her special needs
☐ Nursing Care
☐ Audiology services for hearing problems
☐ Physical therapy
☐ Occupational therapy
☐ Orientation and mobility services
☐ Respite Care
☐ Applied Behavioral Analysis/Behavioral therapy
☐ 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 job skills or vocational education?
☐ Personal assistant or an in-the-home or in-the-classroom aide

Other Comments/Issues/Concerns:

_____

_____

_____

_____

_____