UCLA Resnick Neuropsychiatric Hospital

ADULT PARTIAL HOSPITALIZATION PROGRAM (APHP)
OUTPATIENT REFERRAL FORM

PLEASE FAX to 310-206-1157

Date/Time of Referral: _____

Patient: _____Phone #:_____

Diagnosis:_____

Psychosocial Stressors:_____

☐ Non-UCLA Outpatient
- Please attach updated clinical summary with reason for referral and patient's contact information.

☐ UCLA Outpatient
- Please provide reason for referral and MRN.

APHP Criteria Met:

☐ Availability to Attend Program 4 to 5 Days Per Week.
☐ Demonstrated Ability to Participate in Group Treatment
☐ Normal Cognitive Functioning
☐ Motivated for Treatment
☐ Ability to Concentrate
☐ Stable Housing

If Applicable:

☐ Commitment to Sobriety
☐ If ECT patient, down to at least one treatment per week

Referring Physician: _____ Resident: _____
(Please Print) (Please Print)

Pager #: _____ Phone #:_____ Pager #: _____

Referring Social Worker **or** other Contact: _____
(Please Print)

Pager #: _____ Phone #:_____

Requested Start Date: _____

Please call APHP if you have any questions at (310) 825-7469