

**ADULT PARTIAL HOSPITALIZATION PROGRAM (APHP)**

**OUTPATIENT REFERRAL FORM**

**PLEASE EMAIL THIS FORM TO:** **PHPReferrals@mednet.ucla.edu**

**Date/Time of Referral:**

**Patient:** **Phone #:**

**Diagnosis:­­­­­­­­­­­­­­­­­­­­­­­**

**Psychosocial Stressors:**

**CHECK ONE OF THE BELOW:**

[ ]  **Non-UCLA Outpatient** *(Please include a mental health evaluation and recent progress note along with reason for referral. We don’t accept hand-written notes.)*

[ ]  **UCLA Outpatient**

Reason for referral:

MRN:

**APHP Criteria Met: APHP Telehealth Criteria Met (IF APPLICABLE)**

|  |  |
| --- | --- |
| [ ]  Availability to attend program 4-5 days per week | [ ]  Has a mobile phone, laptop or pc with a camera they can operate |
| [ ]  Demonstrated ability to participate in group treatment | [ ]  Has a working email and independently able to check email |
| [ ]  Normal cognitive functioning | [ ]  Email: ­      |
| [ ]  Motivated for treatment | [ ]  Has Wi-Fi access in secure private setting where they can speak freely |
| [ ]  Ability to concentrate | [ ]  Has Wi-Fi access to support three hours of group for at least three days a week |
| [ ]  Stable Housing |  |
|  [ ]  Commitment to Sobriety (IF APPLICABLE) |  |
| [ ]  If ECT patient, down to at least one treatment per week (IF APPLICABLE) |

Referring Physician:      Resident:

Pager #:       Phone #:      Pager #:

Referring Social Worker **or** other Contact:

Pager #:       Phone #:

Requested Start Date:       **Please call APHP if you have any questions at (310) 825-7469**