

**ADULT PARTIAL HOSPITALIZATION PROGRAM (APHP)**

**OUTPATIENT REFERRAL FORM**

**PLEASE EMAIL THIS FORM TO:** [**PHPReferrals@mednet.ucla.edu**](mailto: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**