

**ADULT PARTIAL HOSPITALIZATION PROGRAM (APHP)/INTENSIVE OUTPATIENT (IOP)**

**PROGRAM REFERRAL FORM**

* ***Please complete all questions on this form. THE FORM MUST BE COMPLETED BY THE PATIENT’S MENTAL HEALTH PROVIDER (i.e. psychiatrist or therapist)*.**
* ***WE DO NOT ACCEPT HAND-WRITTEN NOTES. Please type and submit the electronic version of required documents.***
* ***PLEASE EMAIL THIS FORM TO:*** ***PHPReferrals@mednet.ucla.edu***

**REFERRAL DATE:** **REQUESTED START DATE**:

**PATIENT INFORMATION**

**Name:**       **Date of Birth:**       **Phone #:**

**EMERGENCY INFORMATION**

**Name of Emergency Contact:**

**Relationship to Patient:**

**Phone #:**

**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 |
| [ ]  Has an established outpatient mental health provider AND/OR has been referred to a new mental health provider with a scheduled appointment. |  |
| [ ]  Stable Housing |  |
|  [ ]  Commitment to Sobriety (IF APPLICABLE) |  |
| [ ]  If ECT patient, down to at least one treatment per week (IF APPLICABLE) |

**CHECK ONE BELOW:**

[ ]  **Non-UCLA Outpatient** *(Please include H&P or psychiatric evaluation note and recent progress notes along with the completed referral form.)*

[ ]  **UCLA Outpatient**

MRN:

**REFERRING PROVIDER**

Physician:      Resident:       Pager #:       Phone #:

Social Worker **or** other Contact:       Pager #:       Phone #:

**CLINICAL INFORMATION**

1. **Presenting Problem** (*include onset, duration, and intensity*)**:**
2. **Precipitating Event** *(why seeking for PHP/IOP now)***:**
3. **Past Psychiatric History** *(include history of hospitalization, previous engagement in residential treatment, PHP/IOP, and outpatient care)***:**
4. **Substance Abuse History** *(include type of substance, amount, frequency, duration, first and last use)***:**
5. **Any Relevant Medical Conditions** *(diabetes, hypertension, head trauma, cardiac problems, asthma, cancer, etc.)***:**
6. **Psychosocial Information** *(include support system, school/work life, legal history, etc.)*:

**DIAGNOSTIC IMPRESSION**

**Primary Psychiatric Diagnosis: ­­­­­­­­­­­­­­­­­­­­­­­**

**Secondary Psychiatric Diagnosis** *(include Substance Abuse)***: ­­­­­­­­­­­­­­­­­­­­­­­**

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