ADULT PARTIAL HOSPITALIZATION PROGRAM (APHP)
OUTPATIENT REFERRAL FORM

PLEASE FAX to 310-206-1157

Date/Time of Referral: __________________________

Patient: _____________________ Phone #: __________

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: __________________ (Please Print) Resident: __________________ (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