Department of Psychiatry
Acute Partial Hospitalization Program
P: 617-506-4768 F: 617-474-3836

Carney Hospital
A STEWARD FAMILY HOSPITAL
Steward

Hybrid Program Referral Form

Virtual participation requires: an email address and access to smart phone, tablet, or computer as well as access to wi-fi or data plan. Also must have access to a safe and private place in which to participate. In-person treatment slots are limited at this time. **We will do our best to accommodate but the pt should be aware that virtual participation may be required for all or part of the treatment.**

******To participate in-person: will be COVID screened daily upon arrival to the hospital, must wear a mask at all times, and may be asked to participate virtually if exhibiting any symptoms of illness.***

What type of treatment does pt prefer? _____Virtual _____In-person

Referral source:	**Agency:**	**Phone:**

Patient Information

Name:	DOB:
Living Situation/Address:	
Phone:	Email:

Diagnosis

Primary
Secondary

Reasons for Referral, Include Precipitating Factors

Substance Use: Indicate Use/Misuse/Dependence/Remission

Treatment or Peer Support Services in Use or Previously Used

Support System

Therapist:	Agency:	Phone:
Prescriber:	Agency:	Phone:
PCP:	Agency:	Phone:
Support services in place, i.e. Intensive Case Mgr, ACCS or PACT, Elder Services, DMH Case Manager, VNA		
Name:	Agency:	Phone:
Name:	Agency:	Phone:

Name of Insurance:

Policy #:	Auth #:	Days/Units:

Please include a list of all medications and an H&P if available. Fax all to 617-474-3836