Rev. 07.21

PROGRAMS FOR PEOPLE, INC.

98 Lincoln Street Framingham, MA 01702-9627 Tel 508.879.3230 Fax 508.872.8724

REFERRAL TO DAY TREATMENT PROGRAM

PLEASE PRINT OR TYPE

Laura Hughes, PMHCNS-BC - Director

Date of Application:____/____/____

Referent (Name & License):____ Telephone # ______________________
Referent's Organization:____ Email:____________________________

I. IDENTIFYING INFORMATION

Applicant's Name:____ Telephone #_______________________
Email: ____
Date of Birth:______________ Home Address:______________________________ ________________________
Street Town
Legal Sex (please check one)* __ Female __ Male

*While we recognize a number of genders / sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the legal name and sex listed on the insurance must be used for insurance billing and correspondence. If the applicant's preferred name and pronouns are different from those, please let us know: ____
____

Social Security Number:_____-_____-________ Cultural / Linguistic Background:_________________________

Is this a hospital diversion? Yes ________ No________

HEALTH INSURANCE	Policy Number	Subscriber	If Private Insurance, Contact Person Name	Telephone #

SIGNIFICANT NON-PROFESSIONALS (Include members of applicant's immediate family):

Name	Relationship	Age	Address	Supportive to Applicant	No Contact with Applicant

Who of the above would be willing to accompany applicant to an intake meeting? _________________________________

OUTPATIENT TREATMENT TEAM	NAME	TELEPHONE #
Current Therapist:		
Medicating Psychiatrist/Nurse:		
Case Manager:		
MRC Counselor:		
Primary Care Clinician:		

Applicant's response to this referral? ____
To what degree is applicant motivated to change? ____

II. DSM V DIAGNOSIS:

ICD-10 Code (if known)

Primary Diagnosis: ____
Additional BH/SA Diagnoses: ____
____

III. THE APPLICANT'S PRESENTING PROBLEMS:

A. Chief complaint: ____
____
____

B. Current Stressors and/or precipitant: ____
____
____

C. History of presenting problem: ____
____
____

IV. SUICIDE / HOMOCIDE

A. Ideation: ____
B. Plan / Intent / Means: ____
C. History of Previous Attempts: ____
____

V. MENTAL STATUS

A. Affect / Mood: ____
B. Orientation: ____
C. Memory: ____
D. Intellect / Cognition: ____
E. Perception / Sensation: ____
F. Thought Process / Content: ____
G. Hallucinations / Delusions: ____

VI. FUNCTIONING

A. Ability to Perform Activities of Daily Living (ADL'S) ____
B. Job / School: ____
C. Sleep: ____
E. Appetite: ____

VII. PREVIOUS MENTAL HEALTH TREATMENT

Agency, Hospital, Therapist	Precipitant	Dates	Length of Stay (LOS)

VIII. SUBSTANCE ABUSE HISTORY

Name of Substance	Amount of Use	Frequency	Treatment	Date of Last Use

Does Applicant consider substance use a problem? Yes: ____________ No: _____________
What is applicant's commitment to sobriety: ____
What is the plan to attain/maintain sobriety? ____
____

IX: CURRENT MEDICATION(S) (Include medications for psychiatric and non-psychiatric conditions)

Name of Drug	Dosage	Frequency
	Mg.	
	Mg.	
	Mg.	

X. NICOTINE USE

Does the client use nicotine? ______________________________

If so, in what form? ______________________________

How often (if cigarettes, how many)?______________________________

XI. SIGNIFICANT MEDICAL HISTORY AND ALLERGIES

A. Pertinent medical history: ______________________________

B. Allergies: ______________________________

C. Covid-19 Vaccine Status: ______________________________

XII. FAMILY / DEVELOPMENTAL

Relationship	History of Mental Illness	History of Substance Abuse
Mother		
Father		
Sibling		
Other		

Applicant's history of abuse, neglect (domestic, sexual, physical, emotional)
____
____

Social History: ______________________________
____

History of Military Service: ______________________________

XIII. TREATMENT PLAN (In addition to day structure)

A. Focus / Goals: ______________________________
____

B. Obstacles of Treatment: ______________________________
____

C. Previous Treatment Progress / Goals Achieved: ______________________________
____

D. Expected Response / Compliance to Treatment at Programs for People: ______________________________
____

E. Special Circumstances:
Assaultive Behavior: ______________________________
Involved in Court Action: ______________________________
Does Client have Access to Weapons: ______________________________
Legal Guardianship: ______________________________

F. Estimated Length of Stay (ELOS): ______________________________

How will the client get to and from Programs For People every day? ______________________________
____

NOTE: We appreciate your taking the time to complete this form. We must have the above information prior to admission. This information may also be necessary for obtaining authorization for services, and for this reason we are required to obtain a "release" signed by the applicant prior to making the authorization call. Please use the attached form and submit it with this referral form. Thank you.

DO NOT EMAIL COMPLETED REFERRAL FORM. Please Fax (508-872-8724) Or Mail The Completed Form.

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DAY TREATMENT PROGRAM

Release of Information Agreement
for
INSURANCE PAYOR

I______________________________________, give my permission for Programs For People, Inc.
(applicant's name)

to give information regarding my case to my insurance payor _______________________________________
(name of insurance payor*)

as requested. I understand why the information is needed and am satisfied that the material will be considered confidential.

____
Signature of Applicant/Guardian

____
Signature of Referent

____
Date

____
Witness Name