Lindner Center of HOPE | UC Health

4075 Old Western Row Rd., Mason, Ohio 45040

MINDFUL TRANSITIONS
ADULT PARTIAL HOSPITALIZATION SERVICES
EXTERNAL REFERRAL FORM FOR SERVICES

External Referral Form for Services

Once form is complete, print and fax to (513) 536-0509, call Lindner Center of HOPE at (513) 536-HOPE (4673), state you are a referrer and ask for intake to continue referral process.

Date of Referral: ____________________ Please complete all fields.

Demographic Information			
Name of Patient:		DOB:	
Address:			
Best Contact #:		Email:	

Insurance Information			
Insurance Co.:			
ID#:		Group #:	
Subscriber Name:		DOB:	
# To Verify Benefits:			

Referral Source			
Referrerl Name:			
Agency:			
Phone/Fax:		Email:	
How long have you had a clinical relationship with this patient?			

Clinical Information

Brief Current Update

Clinical Goals for PHP	
Primary Goal:	
Secondary Goal:	

Current Diagnosis	
I:	
II:	
III:	
IV:	
V:	

Previous Inpatient and/or detox hospitalizations: Specify dates, facilities and brief reason:

Trauma History

4/14

Lindner Center of HOPE | UC Health

4075 Old Western Row Rd., Mason, Ohio 45040

Substance Abuse History (please include nicotine usage)
Longest Period of Sobriety / When?

Please List All Current Medication(s) and Dosages (name/dose)	

Do you feel patient is medication compliant ?	
If no, please explain.	
Are you looking for medication adjustments/recommendations?	
If so, preferred communication of changes/recommendations?	

Current Chronic/Acute Medical Conditions

Allergies (please list all including food and/or environmental)	

Current Outpatient Treatment Team: Please indicate who will prescribe POS AND PHP			
Psychiatrist:		Other:	
Therapist		Other:	
Primary Care:			

Behavioral Issues:	Active:	Past (when?):
Binge Eating		
Purging (self-induced vomiting)		
Self-Harm (cutting, burning etc.)		
Excessive Exercise		
Other (specify)		

Comments/Other Relevant Information: