MR#________________
(OFFICE USE ONLY)

CHILD AND ADOLESCENT PARTIAL HOSPITALIZATION SERVICE (CAPHS)

DEPARTMENT OF PSYCHIATRY

OUTSIDE OF MONROE COUNTY FORM

Phone (585) 273-1779 Fax (585) 273-1386

Email - ChildandAdolescentPartialIntakeTeam@URMC.Rochester.edu

PATIENT: ______________________ DOB: ________ Age: ____ Gender: ____ Ethnicity: __________

Address: ____

City: ______________ State: ______________ Zip: __________ County: ______________

School: __________________ Special Education? ____________ Grade: ______________

PARENT /GUARDIAN:

Name	Relationship to Patient	Home Number	Work Number

INSURANCE:

Coverage: ______________________ Contract #: ______________________

Primary Care Physician: ______________________ Phone #: ______________________

CLINICAL DATA:

Mental Health Diagnosis: ____

Mental Health Diagnosis: ____

Medical Concerns: ____

Psychosocial Stressors:
(Z Codes) ____

Has patient had any prior psychiatric hospitalizations? If yes, specify when & where:

____

____

CURRENT PSYCHOTROPIC MEDICATIONS: (Past Trials/ Current Regimen)

Medication	Dosage	Target Symptoms	Response	Start Date	End Date

Referral must be accompanied by a copy of a current clinical summary and a signed release of information form.

RISK FACTORS:

	Current Episode	Past History		Current Episode	Past History
Affective instability	☐	☐	Poor impulse control	☐	☐
Alcohol/substance abuse	☐	☐	Property destruction	☐	☐
Anorexia	☐	☐	School avoidance	☐	☐
Anxiety	☐	☐	School problems	☐	☐
Bulimia	☐	☐	Self-mutilation	☐	☐
Depression	☐	☐	Sexual acting out	☐	☐
Eating problems	☐	☐	Sleeping problems	☐	☐
Encopresis / Enuresis	☐	☐	Social withdrawal	☐	☐
Hallucinations/delusions	☐	☐	Suicidal ideation	☐	☐
Hyperactive/inattentive	☐	☐	Suicide attempt	☐	☐
Language processing/LD	☐	☐	Temper outbursts	☐	☐
Low cognitive functioning/MR	☐	☐	Thought disorder	☐	☐
Oppositional/defiant	☐	☐	Threatening	☐	☐
Physically assaultive	☐	☐	Poor impulse control	☐	☐

DOES THE PATIENT HAVE DIABETIES/ASTHMA OR ANY OTHER MEDICAL ISSUE? ☐ **Yes** ☐ **No**

If yes, what is the medical issue and who are the providers? ______________________________

CPS/ LEGAL INVOLVEMENT: ______________________________

____

GROUP EXPERIENCE: How does patient do in group? ______________________________

____

PATIENT'S CHIEF COMPLAINT: ______________________________

____

THERAPIST/PROVIDERS REASON FOR REFERRAL:

____

Referring Provider:
Name: ____________ Phone: ____________ Fax: ____________
Address:

Referral must be accompanied by a copy of a current clinical summary and a signed release of information form.

CURRENT TREATMENT PROVIDERS:

Outpatient Therapist: Yes / No					
Name:	______	Phone:	______	Fax:	______
Address:					

Outpatient Psychiatrist: Yes / No					
Name:	______	Phone:	______	Fax:	______
Address:					

Case Manager: Yes / No					
Name:	______	Phone:	______	Fax:	______
Address:					

Additional Emergency Contacts: Yes / No					
Name:	______	Phone:	______	Fax:	______
Address:					

LOCAL EMERGENCY SERVICES:

Psychiatric Mobile Crisis Team: Yes / No					
Name:	______	Phone:	______	Fax:	______
Address:					

Psychiatric Emergency Department: Yes / No					
Name:	______	Phone:	______	Fax:	______
Address:					

Local Suicide Hotline: Yes / No					
Name:	______	Phone:	______	Fax:	______
Address:					

Other Local Emergency Services: Yes / No					
Name:	______	Phone:	______	Fax:	______
Address:					

***In order for your patient to be eligible for Partial Hospitalization Via Telehealth, the patient must have**

- Access and availability to consistent internet (ex: hotspot, broadband, Wi-Fi)
- Access to a devise with a working camera and microphone (ex: Computer, Chromebook, Tablet, Smartphone)
- A private place to engage in individual and group therapy
- Willingness to engage in treatment – sitting up and dressed daily.
- A responsible adult in the home to assist in mobilization of the patient, support with implementation of coping strategies, fielding phone calls from the treatment team, and ability to respond in an emergency situation.

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