



**WEB REFERRAL FORM  
PHOENIX ADULT PARTIAL HOSPITALIZATION PROGRAM**

250 EAST FAYETTE STREET  
UNIONTOWN, PA 15401  
PHONE #: 724-437-1151  
FAX #: 724-437-4915

**NAME:** \_\_\_\_\_ **BSU #:** \_\_\_\_\_  
**DOB:** \_\_\_\_\_ **SSN #:** \_\_\_\_\_  
**ADDRESS:** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ **DATE OF REFERRAL:** \_\_\_\_\_

**CONTACT PERSON/RELATIONSHIP:** \_\_\_\_\_  
**PHONE #:** \_\_\_\_\_

**PERSON/AGENCY MAKING REFERRAL:** \_\_\_\_\_  
**PHONE #:** \_\_\_\_\_

**CONSUMER'S CASE MANAGER:** \_\_\_\_\_  
**PHONE #:** \_\_\_\_\_

**CONSUMER'S CURRENT TREATING PHYSICIAN:** \_\_\_\_\_  
**PHONE #:** \_\_\_\_\_

**CONSUMER'S THERAPIST:** \_\_\_\_\_  
**PHONE #:** \_\_\_\_\_

**CONSUMER'S CURRENT PCP:** \_\_\_\_\_  
**PHONE #:** \_\_\_\_\_

**REASON FOR REFERRAL/EXPECTED OUTCOME:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DIAGNOSES:**  
**AXIS I:** \_\_\_\_\_  
**AXIS II:** \_\_\_\_\_  
**AXIS III:** \_\_\_\_\_  
**AXIS IV:** \_\_\_\_\_  
**AXIS V: CURRENT GAF IS APPROXIMATELY** \_\_\_\_\_

**CURRENT MEDICATIONS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ACTIVE MEDICAL PROBLEMS:**  
\_\_\_\_\_  
\_\_\_\_\_

**DRUG & ALCOHOL ISSUES:** \_\_\_\_\_

**LEGAL ISSUES:** \_\_\_\_\_

**AVAILABLE SUPPORT SYSTEM/FAMILY:** \_\_\_\_\_

**OTHER AGENCY INVOLVEMENT:** \_\_\_\_\_

**INDICATIONS FOR PARTIAL HOSPITALIZATION SERVICES:**

- This service would divert the individual from acute psychiatric inpatient care or would shorten the length of the hospital stay.
- This service would provide crisis stabilization and treatment to a chronically ill patient currently in treatment who requires more intensive service for some period of time than I provided in outpatient or aftercare programs.
- This service would permit an intermediate or long-term patient to return to the community.

**OTHER INFORMATION:**

- This individual is interested in and willing to receive this service at this time.
- This individual is (or will be) ordered by law to receive this service at this time.
- This individual has impairment of speech, hearing, sight, ambulation, continence, or other sensory or physical function.
- This individual resides in a supervised community residence.
- This individual has own transportation: (  personal;  FACT)
- This individual needs transportation: (  MA-Eligible;  Third Party)

**I agree to a referral for adult partial hospitalization services.**

**SIGNATURE OF CLIENT:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**SIGNATURE OF PERSON MAKING REFERRAL:** \_\_\_\_\_