SAINT VINCENT HOSPITAL

Partial Hospital Program (PHP)

299 Lincoln St. Worcester MA 01608

Referral Form

Phone: (774) 420-3844 Fax: (508) 854-4105

Evenings & Weekends, Call (508) 650-7380

CLIENT INFORMATION			
Client's Name:			Date:
DOB:	SSN#:	Client Phone #:	
Address:		City:	Zip Code:
Presenting Issue:			
Level of Care: MH ☐ DD ☐ ADOL ☐		Start Date:	
Currently Inpatient: ☐ Yes ☐ No If yes, Unit:		Phone:	D/C Date:
Mode of Transportation:			

INSURANCE	
Insurance:	Policy#
Subscriber:	Policy Managed by:
Phone#:	Tufts Cap? ☐ Yes ☐ No
*INPATIENT and EMERGENCY SERVICES Please Try To Include Insurance Authorization	
Authorization #:	Days Authorized:
Review Date:	Review with (name of ins. Reviewer):

REFERRAL SOURCE	
Referring Organization:	Referral Phone:
Contact Name:	Referral Email:

	Provider/Agency	Phone Number
Psychiatrist		
Therapist		
PCP		
Suboxone/Methadone		
Case Manager		
Other		

Treatment Goals:

***All Referral Sources Attach the Following:**

☐ Face Sheet (with insurance information) ☐ Current Medication List

☐ Most Recent Assessment

Inpatient Programs Please Include

☐ History and Physical/Admission Note ☐ Recent MD Notes ☐ Social Work Assessment

☐ Discharge Information Discharge Date (if inpatient):

OFFICE USE ONLY	
Appt. Time & Date:	**Appt Kept**: ☐ Yes ☐ No,
Reminder Call, Date:	Reschedule ☐ Yes ☐ No, Date & Time: