Cincinnati Children's
changing the outcome together

Partial Hospital Program Request Form

Psychiatric Intake Response Center Phone: (513) 636-4124 Fax: (513) 803-8173

Name: _____

DOB: _____

MRN: _____

Please complete the document in its entirety and provide enough information to support clinical criteria for admission to a partial hospital program. Please fax completed document to (513) 803-8173 for our review. Acceptance of your patient is based on clinical and medical appropriateness.

Requesting: ☐ Green Township ☐ Norwood

SECTION I: DEMOGRAPHICS

Patient's Name: _____ Date of Birth: _____ Age: _____

Patient Address: _____

_____

Legal Guardian Name: _____ Primary Contact Number: _____

Is the guardian able to participate in admission and family meetings: ☐ No ☐ Yes

Insurance Company Name: _____

SECTION II: CLINICAL INFORMATION

Provider Name & Credentials: _____ Agency/Facility Name: _____

Phone: _____ Phone (after hours): _____

Email: _____

Please check the boxes indicating the reasons for referral:

☐ Self-injury ☐ School refusal ☐ Increased in level of care/inpatient diversion

☐ Decrease in ADL's ☐ Other: _____

Increase in psychiatric symptoms despite outpatient treatment:

☐ Depression ☐ Anxiety ☐ Psychosis ☐ Homicidal Ideation ☐ Suicidal Ideation

☐ Aggression ☐ Risky behavior ☐ OCD ☐ Other: _____

For each check box, please provide description: _____

_____

_____

_____

What interventions have been attempted? _____

_____

_____

How long has this crisis been going on? _____

DSM V Diagnoses:

1. _____ Severity: ☐ Slight ☐ Mild ☐ Moderate ☐ Severe

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SECTION III: SOCIAL AND BEHAVIORAL HEALTH HISTORY

Current Behavioral Health Provider(s): _____

_____

Does patient have a history of aggression or current aggression towards others? ☐ No ☐ Yes

If yes, explain: _____

_____

School Name: _____ Grade: _____

IEP or 504 Plan ☐ No ☐ Yes ☐ Unknown

Are there any concerns for developmental or cognitive delays? ☐ No ☐ Yes

If yes, explain: _____

_____

_____

Problems with school?

☐ None	☐ Peers	☐ Attention	☐ Concentration	
☐ Tardiness	☐ Truancy	☐ Authority	☐ Homework	☐ Motivation
☐ Learning Ability	☐ Victim of Bullying	☐ Bullying	☐ Aggression	☐ Fighting

☐ Other: _____

Strengths in School: _____

Limitations in School: _____

SECTION IV: MEDICATION/MEDICAL HISTORY

Primary Care Physician Name: _____ Phone: _____

Allergies/Intolerances: ☐ No ☐ Yes If yes, describe: _____

Current medications: ☐ None ☐ Yes, please list below

Name	Dosage	Route of Administration	Date/Time of Last Dose	Indication

Is patient compliant with medications? ☐ No ☐ Yes

If no, describe: _____

History of psychiatric medications, if known: _____

_____

Weight: _____ Height: _____ Recent change in weight: ☐ No ☐ Yes

If yes, describe: _____

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SECTION IV: MEDICATION/MEDICAL HISTORY (continued)

Does patient have an eating disorder? ☐ No ☐ Yes *Not accepting EDO patients at this time.*

a. Current Ideal Body Weight: _____ BMI: _____

b. Orthostatic Vital Signs: Sitting Blood Pressure: _____ Heart Rate: _____

Standing Blood Pressure: _____ Heart Rate: _____

c. Please attach all labs/tests demonstrating medical clearance for Eating Disorders, including:
- EKG – completed within the last 7 days
- CBC w/differential – completed within the last 3 days
- Complete Metabolic panel – completed within the last 3 days

Medical Concerns: ☐ None ☐ Diabetic* ☐ Seizure disorder ☐ Asthma ☐ Recent head trauma
☐ C-Pap for Sleep ☐ Dialysis ☐ Cardiac ☐ Pregnant ☐ Inability to swallow pills
☐ Suicide attempt in the last two weeks that needed medical intervention

☐ Other: _____

If any checked, describe: _____

**If the patient is on an insulin pump, the pump must be removed and the patient must be converted to injections prior to admission*

Nursing Concerns: ☐ None ☐ Feeding Tube ☐ Wound Care ☐ Incontinent ☐ Encopresis ☐ Fall risk ☐ Trach

Describe specific nursing needs: _____

Is patient able to ambulate independently? ☐ No ☐ Yes

If no, describe: _____

Is patient able to manage their ADL's? ☐ No ☐ Yes

If no, describe: _____

Signature of provider completing form/Credentials Printed Name Date/Time

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Please use this checklist to confirm you have completed and provided all necessary information:			
☐ Yes	☐ No		Document is complete
☐ Yes	☐ No		Document illustrates medical necessity for admission
☐ Yes	☐ No		Parents/Guardian in agreement
☐ Yes	☐ No		Attached is a copy of the front and back of patient's insurance card
☐ Yes	☐ No	☐ N/A	Medication documented
☐ Yes	☐ No	☐ N/A	Labs, including EKG attached (Required for any Eating Disorder diagnosis)

CCHMC use only:

Form reviewed by signature Printed Name Date/Time