UMass Memorial Health
MARLBOROUGH HOSPITAL

PARTIAL HOSPITAL PROGRAM REFERRAL FORM

Phone: 508-486-5547 Fax: 774-843-7372 Email: PHPMarlborough@UMassmemorial.org

☐ **In Person** ☐ **Virtual** ☐ **Hybrid**

REFERRAL MUST INCLUDE:

MOST RECENT ASSESSMENT AND/OR PROGRESS NOTES
DISCHARGE INFORMATION (IF REFERRED AS A STEP DOWN)
CURRENT MEDICATIONS
MOST RECENT PHYSICAL EXAM

PLEASE FAX or Email THIS COMPLETED FORM WITH ATTACHMENTS

Referred by (Name):	Date:
Agency:	Phone Number: FAX:

Client Name:	**Client Email Address:**
Phone Number:	SS#:
Is transportation to program needed: Y N	Date of Birth:
Address:	
City: State: Zip:	Discharge Date (if applicable):

Type of Insurance:	Auth# for PHP (if stepdown from inpt):
Ins Subscriber & DOB:	ID#:

ICD 10 Diagnosis (code/description)	Please explain if any history of the following:
	Trauma:
	Suicidal/Homicidal:
	DCF/DDS/DMH involved:
	Legal Involvement:

PRESENTING PROBLEM(S): (Please include substance abuse status):
Client's Motivation for Treatment: ☐ High ☐ Moderate ☐ Ambivalent
Goals for Treatment:

PROVIDER INFORMATION:	*Address/Agency*	*Phone Number*
Psychiatrist:		
Therapist:		