

# ADULT PARTIAL HOSPITAL PROGRAM

Rhode Island Hospital, Potter 2 - Tel. (401) 444-2128

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**Rhode Island Hospital**  
*Lifespan. Delivering health with care.™*

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## REQUEST FOR SERVICES / Please check one:

**Adult Track**

**Young Adult Track**

**Trauma/PTSD Track**

Date to Start Treatment: \_\_\_\_\_

PHP to contact Patient? Yes      No

Patient Contact # \_\_\_\_\_

**Referral Source (Name):** \_\_\_\_\_

**Phone #:** \_\_\_\_\_

**Fax #:** \_\_\_\_\_

**Email:** \_\_\_\_\_

### Demographic Information

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Legal Name (if different) \_\_\_\_\_

Sex - M \_\_\_\_\_ F \_\_\_\_\_ \* Gender Identity \_\_\_\_\_ \*Pronouns he/she/ \_\_\_\_\_

*\* In effort to make our practice more inclusive, we have provided space for **optional** self-identification for our transgender or gender non-conforming patients. If this information does not apply, you may leave it blank.*

Race \_\_\_\_\_ Relationship Status \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Insurance Information

Primary Insurance: \_\_\_\_\_

Policy #: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Policy #: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

### Clinical Information

Admit From: \_\_\_\_\_

(Attach D/C summary, medication information and any other pertinent information)

Reason for transfer: \_\_\_\_\_

#### Diagnoses:

Primary: \_\_\_\_\_

Secondary: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Outpatient Therapist: \_\_\_\_\_ Outpatient Psychiatrist: \_\_\_\_\_