

**McLean Hospital**  
**Borderline Center in the Behavioral Health Partial Hospital Program**

**Treatment Agreement**

Collaboration is one of the most important aspects of treatment in the Borderline Center. We want to work with you in your struggle to gain control over your life.

You will begin your intensive treatment in the Borderline Specialty Track of Behavioral Health Partial Hospital Program. There are two main components of treatment: one is for borderline personality disorder and the other is for mood and anxiety issues that are usually associated with BPD.

The fact that you are here indicates you have already tried many ways to handle your problems which have not worked, and have probably been destructive to you and people close to you. This treatment program will be difficult for you. It requires you to face upsetting issues without resorting to the unhealthy and destructive behaviors that have lead you to come here. To learn healthier ways of coping will require hard work and a commitment to treatment. This commitment means you are working with the treatment team to follow your treatment plan. The more you can stay connected and develop trust with the people involved in your treatment, the more likely you will make progress.

We expect you to make a good-faith effort to follow your treatment plan and take responsibility for your behavior. Below is a list of expectations that are necessary for a successful treatment and to remain in the Partial Hospital Program:

- Commitment to change as demonstrated by your behavior.
- Follow the house-rules at the Transitional Living Center—TLC (if you are living there)
- Daily attendance in the partial hospital program (Monday—Friday, at least 3 groups per day, individual sessions/ appointments are in addition to groups.)
- Responsible behavior in the treatment milieu
- Make every effort to change unhealthy ways of coping. If you need help we expect you to let us know.
- Agree on an initial crisis plan, and then refine it as treatment proceeds.
- Refrain from behaviors potentially harmful to yourself and to others (e.g., violent behavior, self-harm behaviors, use of drugs or alcohol, sexual or romantic relationships with patients in the program). You will also be expected to comply with random urine screens.
- Maintain a healthy diet and weight and follow recommendations of the clinical /medical staff
- Make an effort to stay connected, especially when you feel badly. Treatment usually fails when patients feel alone and disconnected, and then choose behaviors based on painful feelings and impulsive urges.

It is likely that you will have difficulty meeting all of these expectations. If you cannot fulfill these expectations, the treatment team will review the situation with you and your family. We will determine if you should continue in the program or be discharged. If the decision is for you to stay, it will be considered a probationary period. Another transgression will most likely result in discharge. Such a discharge must be planned for, and agreed upon, with patient and family before admission to the program.

Reviews of the behavioral expectations of enrollment to the Partial Hospital Program will be negotiated with the patient's Clinical Team Manager, Residential Program Director, and Individual Therapist on a regular basis.

\_\_\_\_\_  
Patient's Signature                      Date

\_\_\_\_\_  
McLean Team Member Signature                      Date

**McLEAN HOSPITAL**  
**The Center for the Treatment of Borderline Personality Disorders**  
**REFERRAL FORM**

Date of Referral: \_\_\_\_\_

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

Tel. # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_

Referred By: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ ID #: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Tel. # to verify benefits: \_\_\_\_\_

**Current clinical update for referral to partial hospital:** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

**Goals for referral to Behavioral Health Partial:** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

**Dx:**

I \_\_\_\_\_ II \_\_\_\_\_

III \_\_\_\_\_ IV \_\_\_\_\_ V \_\_\_\_\_

Current living situation: \_\_\_\_\_

Transportation to program: \_\_\_\_\_

Previous inpatient and/or detox hospitalizations: Specify dates, facilities & reason:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Substance abuse history:**

Drug	(check)	Amount	Frequency	Date of last use
Alcohol				
Cocaine				
Heroin				
Opiates				
Marijuana				
Other				

Longest period of sobriety & when: \_\_\_\_\_

History of an Eating disorder: Yes \_\_\_\_\_ No \_\_\_\_\_

Current Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Current Medications and dosages:**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Last blood level results for medications if indicated: \_\_\_\_\_

**Medical conditions:** \_\_\_\_\_

\_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Current outpatient treatment team:**

Pharmacologist: \_\_\_\_\_ Phone #: \_\_\_\_\_

Therapist: \_\_\_\_\_ Phone #: \_\_\_\_\_

PCP: \_\_\_\_\_ Phone #: \_\_\_\_\_

Other: \_\_\_\_\_ Phone #: \_\_\_\_\_

History of Suicide Attempt(s): Specify dates & means \_\_\_\_\_

History of Self-injurious Behavior: Specify frequency, means and last occurrence: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

History of Trauma: \_\_\_\_\_

Current safety status: Self: \_\_\_\_\_ Other: \_\_\_\_\_

	Yes	No		Yes	No
Legal Problems:	<input type="checkbox"/>	<input type="checkbox"/>	Court Date:	<input type="checkbox"/>	<input type="checkbox"/>
Charges Pending:	<input type="checkbox"/>	<input type="checkbox"/>	Restraining Order:	<input type="checkbox"/>	<input type="checkbox"/>

Forward copies of the following information: Admission Note; History/Physical and Psych Testing if available.

\_\_\_\_\_  
Signature

Fax completed form to Corina Kopp @ 617-855-3723