

**McLEAN HOSPITAL  
Hill Center for Women  
REFERRAL FORM**

Date of Referral: \_\_\_\_\_  
Day Treatment \_\_\_? Residential \_\_\_?

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

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

Tel. # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

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

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

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

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

**Secondary insurance:** \_\_\_\_\_ ID #: \_\_\_\_\_

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

**Current clinical update for referral to the Hill Center:** \_\_\_\_\_

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

**Goals for referral to the Hill Center:** \_\_\_\_\_

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

**Dx:**

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

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

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

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

Previous Inpatient/Hill Center and/or detox hospitalizations: Specify dates, facilities & reason:

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

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**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"/>

Please explain: \_\_\_\_\_

How did you hear about our Program?

Internet: specify search engine \_\_\_\_\_  Conference: specify (i.e. ISSTD) \_\_\_\_\_

Printed Ad: specify \_\_\_\_\_  Other: specify \_\_\_\_\_

Forward copies of the following information: Admission Note; History/Physical and Psych Testing if available.  
Please fill out form completely. Incomplete forms will delay the admission process.

Thank you for referring your client to The Hill Center for Women at McLean Hospital. In order to expedite the referral process, we would like to inform you of our precertification procedures. Once your client has completed an intake with the clinical staff at The Hill Center, you will receive a phone call from the clinician doing the intake with information regarding the client's acceptance or denial to the program. If your client is accepted, you, as the referring clinician, will be expected to obtain the precertification of coverage for the program. We ask that the referring clinician obtain the precertification for the program because of your better knowledge of the patient, and therefore, better likelihood of approval for benefit coverage. Most insurance companies require that you see your client, obtain the precertification all within 24 hours of your client starting our program. If you require information about our facility in order to complete the precertification, feel free to contact Dr. Stephanie Rickey at 617-855-3314. Thank you for your assistance. We look forward to working with you and your client.

\_\_\_\_\_  
Signature

Fax completed form to our Admissions Coordinator at 617-855-3738

Admit Hill form 05/11  
AET