Guthrie Robert Packer Hospital Behavioral Sciences

Partial Hospitalization Program

The partial hospitalization program at Guthrie Robert Packer Hospital is an intensive outpatient service for individuals who are struggling with mental illness symptoms but do not require inpatient psychiatric admission. The program is an effective way to actively learn and practice new coping strategies, while also being able to return home daily.

Program Details:

- Monday through Friday, 8:30 a.m. to 12:30 p.m.
- Behavioral Science Unit on the Guthrie Robert Packer Hospital campus
- Group therapy, medication management, case management
- Average length of program is 10-15 days
- Assistance accessing transportation support is available for some individuals

Appropriate for:

- Ages 18 and up
- Patients who are able to sit and focus for four hours

Individuals with psychosis would be evaluated for appropriateness on a case-by-case basis. Individuals with drug and alcohol issues must have a primary mental health diagnosis to participate in the Partial Progarm.

Referrals are required, and any provider may refer a patient. For information or to make a referral, call Janelle LaMontagne, MA, CMHC, CTP, Behavioral Health Practitioner, at **570-887-5207** (office) or **570-890-1194** (cell).

Referrals can also be made in Epic, and a referral form can be found in the Referring Providers section at **www.Guthrie.org**.

GUTHRIE

www.Guthrie.org

ROBERT PACKER HOSPITAL
Behavioral Health

Partial Hospitalization Program
Referral Tool
Janelle LaMontagne, MA CMHC 570-887-5207

Date: _____ **B#:** _____ **D.O.B.:** _____
PT NAME: _____ **Age:** _____ **Gender @ Birth:** ☐ M ☐ F
Address: _____ **Phone #:** _____
REFERRAL SOURCE: _____
Contact Name: _____
Contact Phone: _____ **Contact Fax:** _____

PSYCHIATRIC HISTORY

Current Diagnostic Impression (DSM 5/ICD 10)
Please list primary diagnosis **FIRST** and **include ALL diagnoses** from former Axis I & II

_____
_____
Suicidal Ideation: ☐ Yes ☐ No **Plan:** _____
_____
Past Attempts: _____
Homicidal Ideation: ☐ Yes ☐ No **Plan:** _____
Past Violence: _____
Past Admissions: _____
Family History & Suicides: _____
Psychotic Symptoms: _____
Alcohol Use: ☐ Yes ☐ No **How much:** _____ **Last used:** _____ **First use:** _____
Substance Use: ☐ Yes ☐ No **How much:** _____ **Last used:** _____ **First use:** _____
Legal Issues (Current & Past): _____
_____
Current Provider: _____ **Phone:** _____
Medications: _____
_____

ADDITIONAL INFORMATION:

Reason for Referral: _____
_____
_____
_____
_____
_____

Please return to: Janelle LaMontagne, MA CMHC **PLEASE SEND OFFICE NOTES WITH REFERRAL**
Fax#: 570-887-5407 or email: Janelle.LaMontagnepark@guthrie.org
Please do not write below this line

Reviewed with Doctor: _____ **Date:** _____ **Time:** _____
Accepted ☐ **Declined** ☐ **Reason:** _____
Staff Signature: _____ **Date:** _____ **Time:** _____

Precertification

INSURANCE: _____
ID#: _____ **PHONE (Spoke to):** _____
PRECERTIFICATION: ☐ YES ☐ NO **AUTHORIZATION #:** _____ **DAYS APPROVED:** ____