DayBridge Referral Form
640 Jackson Street, St. Paul, MN 55101
Phone: 651-254-2402 Fax: 651-254-6655

TODAY'S DATE:

Referring Agency Information			
Agency, Clinic, or Hospital:	Inpatient Unit: Discharge Date:	Phone:	Fax:
Contact Person:	Phone:	Fax:	Pager:

Patient Information		
First Name:	Last Name:	D.O.B.:

Please complete or attach documentation containing the following information:				
Age:	Gender:	Race: Language:	Marital Status:	SS #:

Housing Status: Living Arrangement:	County of Residence:
Home Address: City, State & Zip:	Home Phone #: Alternate Phone #:
Outpatient Psychiatrist Name**:** **If none, please indicate.** Primary Care Provider: Date of last physical:	Phone #:
Case Manager Name: If none, please indicate.	Phone #:

Primary Insurance:	ID #:	Group #:
Secondary Insurance:	ID #:	Group #:

Diagnosis
Axis I:
Axis II:
Axis III:
Current or Recent Chemical Use: ___Use ___Abuse ___N/A Date of Last Use: Drug(s) of Choice: CD Assessment Status: _____ Assessment needed _____ Assessment done Referral made _____ N/A

Is Client Dangerous to Self or Others (currently or by history)? ____Yes ____No
Reason for Referral to Partial Hospitalization
Client need: Client group Readiness: Commitment Status: Follow-up Appointments: Does patient have safe discharge plan with support without inpatient hospitalization?
Please attach History and Physical or initial assessment, ROI, medications list, and current progress notes or MD discharge summary. *Attach commitment papers if applicable. Insurance that we currently do **NOT** accept : Aetna, Ammerica's PPO, Champ VA, MA pending, GAMC, Hennepin Health or Metropolotin Health, Humana, Select Care, UCARE, Value Options, WEA/WEIT, Wisconsin MA.