



Hennepin Healthcare Outpatient Mental Health Programs

External Referral Form

Thank you for your interest in the Day Treatment, Partial Hospital Program, or Dialectical Behavior Therapy Intensive Outpatient Program.

All patients are required to complete an intake diagnostic assessment to determine if the program is appropriate for their care. These programs are completely voluntary and patients must express a desire to participate.

The **Day Treatment Program** is a half-day program of services with a treatment commitment of roughly 3 - 6 months. During this program, daily half-day attendance is expected 4 days per week, Monday through Friday.

Admission criteria

- Persons 18 years of age or older
- Are experiencing acute or chronic symptoms of mental illness
- Recent worsening of symptoms or recent inability to cope with or function due to symptoms.
- Have family and/or community resources necessary to support the patient's safe residence in the community during their involvement in the program.
- Able to attend regularly 4 days a week for 3 hours per day
- Recognition that they may have a mental health problem and a willingness to consider how group treatment could help them
- Cognitively capable of benefitting from therapeutic groups utilizing abstract concepts
- Do not have a history of predatory behavior or aggressive behaviors (verbally abusive or assaultive behaviors) that might place other vulnerable patients at risk.
- Able to remain substance free during programming hours

Day Treatment Phone number: (612) 873-4304

Day Treatment Fax number: (612) 904-4304

The **Partial Hospital Program** is comprehensive full-day program of services that also includes psychiatric medication evaluation and management services. This program runs Monday through Friday and attendance is expected daily for the roughly three week duration of the program.

Admission criteria

- Persons 18 years of age or older
- Approaching criteria for hospitalization but has sufficient resources to maintain safety in an outpatient setting
- Willing and able to participate in an intensive, group-based treatment program and attend daily, Monday through Friday, 10:00am to 3:00pm on Mondays/Wednesdays/Fridays and 10:00am to 3:45pm on Tuesdays/Thursdays, for approximately 3 weeks

- Sufficient awareness of problems and at least contemplating working toward mental health recovery goals
- Agrees to remain free from the effects of alcohol/drugs while participating in PHP
- No history of aggressive/assaultive behavior and no significant antisocial personality traits
- No obvious barriers to program participation such as severe mania/psychosis or developmental disorder/cognitive impairment

Partial Program Phone number: (612) 873-2212

Partial Program Fax number: (612) 873-1697

The **Dialectical Behavior Therapy Intensive Outpatient Program** is certified by the Minnesota Department of Human Services to provide standard, full-model DBT services to adult outpatients. Patients attend weekly individual DBT sessions and a weekly 2-hour DBT skills training group for 12 months. Skills coaching is available by phone 24/7 to DBT IOP participants.

Admission criteria identified by the Minnesota Department of Human Services

- Persons 18 years of age or older
- Meet one of the following two criteria:
 - Have a diagnosis of borderline personality disorder
 - Have multiple mental health diagnoses; exhibit behaviors characterized by impulsivity, intentional self-harm behavior, or both; and be at significant risk of death, morbidity, disability, or severe dysfunction across multiple domains.
- Have mental health needs that cannot be met with other available community-based services or that need services provided concurrently with other services.
- Be at risk of one of the following:
 - Higher level of care (inpatient or partial hospitalization)
 - Intentional self-harm or risky impulsive behavior
 - A mental health crisis
 - Decompensation of mental health symptoms
- Understand and be cognitively capable of participating in DBT as an intensive therapy program
- Be able and willing to follow program policies and rules assuring the safety of self and others
- Exclusionary criteria include:
 - Individual needs would be better met through a higher level of care
 - Inability or unwillingness to consistently participate in the program, especially regarding program policies and safety planning
 - Inability or unwillingness to adhere to the program attendance policy
 - Medically unstable
 - History of predatory behavior that would pose a threat to others
 - A dual relationship would exist between a patient and staff member providing services to the patient if she/he were admitted

DBT IOP Phone number: (612) 873-3422

DBT IOP Fax number: (612) 904-4304

Note to prospective patients: Please ask your outpatient provider to complete the referral form and fax it back to the appropriate program.

Note to outpatient providers: Please send a copy of a recent diagnostic assessment and complete the *Referral Provider Information* and *Identifying Information* sections of External Referral form. If one is not available, please provide current detailed clinical information by completing the all sections of the referral form in order for us to determine that your patient meets criteria for one of these levels of care. Fax the completed form back to the program of interest. The Partial Hospital Program requires commitment to attending daily programming for 15-16 days as an alternative to or step-down following inpatient hospitalization. Day Treatment requires a 3-6 month commitment. Dialectical Behavior Therapy Intensive Outpatient Program requires a 12-month commitment. Please make sure the patient you are referring is able to commit to regular attendance for the duration of the program, has transportation, and, if applicable, childcare. Unfortunately, we are unable to assist patients with severe cognitive deficits that preclude learning, patients who pose a potential threat to others (e.g., sexual predators, criminal backgrounds of victimizing others, violence), or with prominent antisocial traits who have limited capacity for empathy. For further questions regarding any of these programs, please call us at the numbers listed above.

Hennepin Healthcare Outpatient Mental Health Programs

External Referral Form

Referral Provider Information

Referral Program: _____

Referred by: _____ Phone# () _____

Reason for referral: _____

Identifying Information

NAME _____ DOB _____

Address: _____

Phone# () _____ Cell Phone# () _____ Email: _____

Insurance Co: _____ ID# _____

Current living situation: _____

Required information

Does the patient have history of sexual violence, significant antisocial traits, history of predatory behaviors, or recent history of aggressive behavior?

Yes No other: _____

Does the patient have a 1:1 in their living facility for behavior problems, need help with toileting, or need assistance with transfers?

Yes No other: _____

Is the patient willing to meet the program attendance requirements?

(Partial Hospital: daily groups for 3 weeks; Day treatment: daily groups for 4 days per week for 2-6 months; DBT IOP: weekly individual DBT and skills group for 12 months)

Yes No other: _____

Is the patient cognitively capable of engaging in structured group cognitive behavioral therapy?

Yes No other: _____

Other providers (Name, Clinic, Phone, Fax)

Psychiatrist or advanced-practice psychiatric provider: _____

Clinic: _____ Phone# () _____

Psychologist or therapist _____

Clinic: _____ Phone# () _____

Case manager: _____

Organization: _____ Phone# () _____

What problem are being experienced that require this level of care (i.e., mental health concerns and life/medical stressors):

Level of Insight for treatment: _____

Level of Motivation for treatment: _____

****NOTE: Outpatient providers may send a recent comprehensive diagnostic assessment in lieu of completing the following sections.****

Mental Health History:

Previous inpatient psychiatric hospitalizations (specify date, facilities & reason):

Previous treatment programs, medication management, commitments, or therapy services (specify date, facilities & reason):

Psychiatric diagnoses:

History of suicide attempt(s) (specify dates & means):

History of self-injurious behavior (specify what and how often):

History of Violence: _____

History of Sexual Offence: _____

Substance Use history:

Previous chemical dependency programs/groups (specify dates, facilities): _____

Substance	(Check if yes)	Amount	How often	Date of last use
Alcohol				
Cocaine/Stimulants				
Heroin				
Marijuana				
Opiates				
Other				

Medical History:

Current Medications and dosages:

Medical conditions: _____

Allergies: _____

Primary Care Physician: _____ Phone# () _____

Past surgeries: _____

	Check if yes, and include date and relevant details
History of head injury?	
History of loss of consciousness?	
History of seizures?	
Other neurological concerns?	
Electroconvulsive Therapy (ECT) treatments?	

Social history

Raised where and by whom: _____

Siblings: _____

What was it like the household growing up: _____

Marriage(s) (when and how long): _____

Children (specify age): _____

Current Social support: _____

Education history: _____

Educational or learning problems: _____

Current employment: _____

Past employment: _____

Spiritual Beliefs/Cultural _____

Financial Difficulties: _____

Legal History:

DW/DUI (specify dates) _____

Charges for assault/violence: _____

Other charges: _____

Probation Officer: _____ Phone# () _____