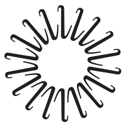

ADULT PARTIAL HOSPITAL PROGRAM
Rhode Island Hospital, Potter 2 - Phone: (401) 444-2128
Referral Line: (401) 444-3748 Fax: (401) 444-8836

REQUEST FOR SERVICES / Please check one:

Adult Track ☐ Young Adult (Ages 18-26) Track ☐ Trauma Track ☐ Borderline Personality Track ☐

Date to Start Treatment: ____________________

PHP to contact Patient? ☐ Yes ☐ No

Patient Contact # ____________________

Referral Source (Name): ____________________

Phone: ____________________ Fax: ____________________

Email: ____________________

Demographic Information

Name ____________________ Date of Birth ____________________

Legal Name (if different) ____________________

Legal Sex - ☐ M ☐ F ☐ Other Gender Identity (optional) ____________________ Pronouns he/she/they ____________

Race ____________________ Relationship Status ____________________ Social Security # ____________________

Address ____________________ City ____________________ State Zip____________

Email Address ____________________ Phone ____________________

Insurance Information

Primary Insurance ____________________

Policy # ____________________ Subscriber Name ____________________

Secondary Insurance ____________________

Policy # ____________________ Subscriber Name ____________________

Clinical Information

Admit From ____________________

(Attach D/C summary, medication information, last progress note, and any other pertinent information)

Reason for transfer ____________________

____

____

Diagnoses

Primary ____________________

Secondary ____________________

Current Medications ____________________

Outpatient Therapist ____________________ Outpatient Psychiatrist ____________________

Trauma Track Referral Form

The Trauma Track delivers evidence-based treatment based on principles of DBT-Prolonged Exposure (DBT-PE) for patients struggling with PTSD and related symptoms.

Please indicate which traumatic events the patient has experienced (check all that apply)		
☐ Childhood Sexual Abuse	☐ Medical Trauma	☐ Childhood Physical Abuse
☐ Sexual Assault/Rape	☐ Childhood Neglect	☐ Warzone/Combat Trauma
☐ Community Violence	☐ Refugee Trauma	☐ Intimate Partner/Domestic Violence
☐ Natural Disaster	☐ Motor Vehicle or Other Accident	☐ Traumatic Invalidation
Other Trauma:		
Of the traumas identified, which is most distressing to the patient and/or source of their most prominent symptoms? (please write)		

Check the PTSD symptoms your patient is experiencing:	
☐ Nightmares	☐ Avoiding reminders of the trauma
☐ Flashbacks	☐ Avoiding thoughts, feelings, or sensations related to trauma
☐ Intrusive thoughts	☐ Difficulties with trust
☐ Feeling on edge/hypervigilant behaviors	☐ Chronically low self-esteem and/or guilt, shame, or self-blame related to trauma
Persistent ☐anger, ☐sadness, ☐fear, and/or ☐disgust	☐ Feeling detached or distant from important relationships
☐ Insomnia	☐ Dissociation and/or feeling numb

Which symptoms of Borderline Personality Disorder and/or emotion dysregulation is your patient experiencing, if any?		
☐ Unstable sense of self	☐ Difficulty controlling anger	☐ Recurrent suicidal behavior/threats
☐ Efforts to avoid abandonment	☐ Mood swings	☐ Pattern of unstable relationships
☐ Impulsivity (substance use, spending, overeating, risky sex or driving)	☐ Self-injurious behavior (e.g., cutting, hitting, burning, picking)	☐ Chronic feelings of emptiness
☐ Not assessed	☐ None observed	

Check any behaviors that your patient uses to avoid painful emotions, thoughts, and/or sensations:			
☐ Dissociation/emotional numbing	☐ Humor	☐ Self-injury	☐ Sleep
☐ Isolation/social distancing	☐ Distraction	☐ Substance use	☐ Hypervigilance
☐ Risk-taking/sensation-seeking	☐ Over-/under-eating	☐ Caretaking	
☐ Treatment interfering behaviors (e.g., attendance issues, homework non-completion,other in-session behaviors)			
☐ Other			

Has the patient had experience with DBT or Prolonged Exposure for PTSD? ☐Yes ☐No ☐Unknown

If yes, please describe context in which treatment occurred and patient response:

DBT-PE Readiness Criteria – Please indicate the readiness criteria your patient meets to assist with track and group placement.	**Yes**	**No**	**Unsure**
Is this patient at imminent risk of suicide? Date of last attempt:__________________	☐	☐	☐
Has there been any recent life-threatening behavior (i.e., suicide attempt), self-injury, substance misuse, or violent behavior in **the past month?**	☐	☐	☐
If applicable, is the patient willing to work on reducing the above behavior(s)?	☐	☐	☐
Is this patient able to use coping skills when triggered instead of self-injury or risky behaviors?	☐	☐	☐
Is PTSD the patient's highest treatment priority?	☐	☐	☐
Is the patient willing and/or able to experience intense emotions without escaping (e.g., using avoidance behaviors listed above)?	☐	☐	☐