



## 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 Program.

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](http://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](mailto: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: \_\_\_\_\_