UPMC | WESTERN PSYCHIATRIC HOSPITAL

ADAPT Program Referral Form

Dear Provider,

Thank you for your referral to UPMC Western Psychiatric Hospital's ADAPT program. The program offers comprehensive dialectical behavior therapy (C-DBT) to adults who have not responded to traditional therapy and treatment available in standard clinics. The program includes learning skills to help manage distress and emotions.

Within 5 business days of receiving your referral, our team will review your patient's information and reach out to discuss next steps. If you do not hear from us within a week, please call **412-246-5600** to confirm receipt.

Sincerely,

The ADAPT Team

Eligibility Criteria

ADAPT participants are Allegheny County residents ages 18 or older with a history of pervasive emotion dysregulation that has caused significant impairment in functioning. Eligible participants must have a history of high-risk behaviors including, but not limited to, self-harm and/or suicidal behaviors resulting in high use of treatment resources such as multiple inpatient hospitalizations, emergency room visits, and utilization of crisis services.

Referring Provider's Responsibility

1. If we are unable to contact your patient, we will ask for your help to connect with them.
2. If the patient ultimately refuses the referral or decides not to participate in ADAPT, we will expect your service to re-engage with your patient.

Instructions

1. Please print out the following referral form (pages 2-5).
2. Complete every section to the best of your ability. Ask your patient for more information if you do not know the answer to a question.
3. To help us best assist you and your patients, please:
   a. Write legibly
   b. Fill in all sections, even if the answer is "not applicable"
   c. Provide as much detail as possible
4. Include patient's signature (required).
5. Scan and email the completed form to:

   Tiffany Painter, *ADAPT Program Director*
   painterl@UPMC.edu

   Or submit by fax to **412-246-5450**.

Patient Information

Name: (First) ______________________ (Last) ______________________

DOB: (mm/dd/yyyy) ______________________

Address: ______________________

City: ______________________ State: ________ Zip: ________

Best phone number: ______________________ Backup phone number: ______________________

Is the patient an Allegheny County resident? ◯ No ◯ Yes

Is the patient a Community Care member? ◯ No ◯ Yes If yes, Medical Assistance (MA) ID#: ☐☐☐☐☐☐☐☐☐☐

Current Providers

Primary therapist or team contact person: ______________________

Phone number: ______________________ Email address: ______________________

Psychiatrist: ______________________ Phone number: ______________________

Service coordinator: ______________________ Phone number: ______________________

Current Symptoms

Please provide detailed information on current behaviors and symptoms to be addressed by ADAPT:

Services/Symptoms in the Past Year

Estimated number of:

- Days in the hospital: ______________________
- Days in Diversion Acute Stabilization (DAS): ______________________
- Behavioral health crisis or emergency department visits: ______________________
- Medical emergency department visits: ______________________
- Episodes of self-harm behavior: ______________________
- Suicide attempts: ______________________

Recent IOP programs: ______________________

Recent PHP programs: ______________________

Describe any past DBT-related experience: ______________________

If a previous treatment program or service was discontinued prematurely, please indicate why:

History of Life-Threatening and High-Risk Behaviors

List the patient's history of life-threatening suicide attempts, self-harm, and/or high-risk behaviors (e.g., setting fires, ingesting foreign objects, eloping, risky sexual behavior, etc.).

	Specific Behaviors/Methods	Outcome (admitted to, etc.)	Date (mm/dd/yyyy)
1.			
2.			
3.			
4.			
5.			

Additional Information

If yes, please explain.

- ☐ Substance abuse? ◯ No ◯ Yes: ______
- ☐ Legal history? ◯ No ◯ Yes: ______
- ☐ Eating disorder? ◯ No ◯ Yes: ______
- ☐ Transportation needs? ◯ No ◯ Yes: ______
- ☐ Tobacco/vaping? ◯ No ◯ Yes: ______
- ☐ Accommodations needed? ◯ No ◯ Yes: ______
- ☐ Strengths: ______
- ☐ Support system: ______
- ☐ Housing placement history: ______

Diagnoses

Behavioral health: ______

Behavioral health: ______

Behavioral health: ______

Medical condition/physical health issue: ______

Medical condition/physical health issue: ______

Medical condition/physical health issue: ______

Current Medications and Dosage

1.____

2. ____

3. ____

4. ____

5. ____

Please list all current medical problems:

Patient Consent *(Confirms awareness of service referral)*

I certify that this specialized service has been explained to me and I am willing to accept these services at this time.

Signature: ____________________________ Date: ______________

If not signed by patient, please explain:

Name and contact information of provider completing referral form: