



Date _____

BOULDER CITY HOSPITAL
Partial Hospitalization and Intensive Outpatient Program Referral Form

Name: _____ SS#: _____ Phone: _____

DOB: _____ Age: _____ Race: _____ Sex: _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip _____

Lives: ☐ Independently ☐ w/Family ☐ Asst Living/Group Home ☐ Skilled Nursing ☐ Homeless ☐ Other _____

Person making referral: _____ Phone: _____ Relationship: _____

Guardian/Payee: _____ Phone: _____ Relationship: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Primary Insurance: _____ Number: _____

Secondary Payer: _____ Number: _____

PRESENTING PROBLEM:

MEDICAL CONDITIONS: Include ambulation devices, hearing and/or visual aids:

PREVIOUS PSYCHIATRIC HOSPITALIZATIONS:

HOSPITAL	APPROXIMATE DATES	REASON	LOS
_____	_____	_____	_____
_____	_____	_____	_____

PREVIOUS OUTPATIENT TREATMENT:

FACILITY	APPROXIMATE DATES	REASON	LOS
_____	_____	_____	_____
_____	_____	_____	_____

To Contact Us: FAX referral to (702) 294-5761 or please call us for additional information at (702) 294-5757