Regions Hospital
HealthPartners

DayBridge Referral Form
640 Jackson Street, St. Paul, MN 55101
Phone: 651-254-2402 Fax: 651-254-6655

TODAY'S DATE:

Referring Agency Information			
Agency, Clinic, or Hospital:	Inpatient Unit: Discharge Date:	Phone:	Fax:
Contact Person:	Phone:	Fax:	Pager:

Patient Information		
First Name:	Last Name:	D.O.B.:

Please complete or attach documentation which must contain all of the following information:

Age:	Gender:	Pronouns:	Interpreter needed? Language:	Marital Status:

Housing Status: Living Arrangement:	County of Residence:

Home Address: City, State & Zip:	Home Phone #: Alternate Phone #:
Outpatient Psychiatrist Name: **If none, please indicate.**	Phone #:
Case Manager Name: If none, please indicate.	Phone #:

Primary Insurance:	ID #:	Group #:
Secondary Insurance:	ID #:	Group #:

Diagnosis:

Current or Recent Chemical Use: ___Use ___Abuse ___N/A
Date of Last Use:
Drug(s) of Choice:
CD Assessment Status: _____Assessment needed _____ Assessment done
Referral made_____N/A

Is Client Dangerous to Self or Others (currently or by history)? Yes No

Reason for Referral to Partial Hospitalization

Client need:

Client group Readiness:

Commitment Status:

Follow-up Appointments:

Does client have enough support to maintain their safety in the community?

Please attach the following clinical documentation:
History and physical or initial assessment ____
Current progress notes or MD discharge summary ____
Medication list ____
ROI ____
Commitment papers if applicable ____

* The following insurances are typically accepted:

- Cigna
- HealthPartners
- Medicaid/Medical Assistance, MN Care and most PMAPs
- MN BCBS
- Medica/Optum Health
- United Health Care/ United Behavioral health
- PreferredOne
- Americas PPO
- UMR
- Medicare (Typically covers up to 80% after deductible, if no supplement)
- TriCare (in person only)

*It is the client's responsibility to check their specific insurance plans regarding in-network benefits and/or copays and co-insurance requirements.