Clara's House | A Place of Healing & Hope
1564 County Road 134 | St. Cloud, MN 56303

Provider Referral Form
Phone: 320-229-4950, Fax: 320-229-4999
clarashousephp@centracare.com

Referral Source: Agency/staff name____________________________ **Date:** _____________
Agency's Phone Number: _______________________

Child's legal Name:	**Preferred: Pronouns:**	**Age:**	**Date of Birth**
Address: **City:**	**State:** **Zip:**		
Legal Guardian: **Contact Person/phone:**		**Phone:**	
School:		**Grade:**	**IEP: Yes/No**
Diabetic: Yes/No	**Seizures: Yes/No**	**Epi Pen for any reason: Yes/No**	
Current Diagnosis: Yes/No Please list:			

Common reasons to refer to Partial Hospitalization Program

- *The patient would likely regress if not in this highly structured setting and may otherwise require hospitalization.*
- *The patient is not progressing in outpatient therapy and a higher level of care is indicated.*
- *The patient is experiencing an acute crisis.*
- *The patient is in need of medication evaluation, treatment, and monitoring.*
- *The patient is in need of further diagnostic clarification and evaluation.*
- *The patient needs more structure and support than they are currently receiving.*

Please explain why you believe the patient needs this level of care:

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Please attach the following information: *Current diagnostic assessment, progress notes from the past three months, and any other information that would support the referral to Clara's House. Once the information has been received the referral will be reviewed and the family will be contacted regarding admission.*