



Bradley REACH at Apalachee Center Provider Referral Form

Dear Referring Provider,

Thank you for your interest in Bradley REACH at Apalachee Center. Please take some time to read below about our virtual program. We ask that you share the program requirements with the families and mark off which they are willing to fully engage in. Once you complete and submit this referral, our clinical staff will reach out to the family to schedule and complete an intake session with them.

Based on the clinical severity of the client, school concerns and insurance, we will work with the family to determine if they are a good fit for the program. Our clinical team will take all factors into consideration and guide the family through the process of enrolling. If you'd like more information, please visit BradleyREACH.org.

– Bradley REACH at Apalachee Center Team

Bradley REACH at Apalachee Center Requirements

Our virtual partial hospitalization program (PHP) is an extended day program that occurs five days a week for teenagers who might be struggling at home, in school or other environments due to serious emotional, behavioral or relationship issues. Partial programs can be an effective diversion from inpatient care and to support discharge (“step down”) from inpatient treatment. Our programs are designed to build coping skills, reduce or eliminate self-harming behaviors, manage the symptoms of anxiety and depression and avoid inpatient hospitalization. Telehealth allows patients to participate in the program while living safely at home. It makes it easy for families to play an active role in their teenager’s care.

Families being referred must agree to the following (*check all that they agree to*):

- Child is willing to engage in the fully remote program Monday through Friday 8 a.m. – 2 p.m.
- Family is willing to support the adolescent’s engagement and participate in twice weekly therapy sessions
- You understand that the program, on average, lasts approximately 18-22 days



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Provider Referral Form**

Youth Information

Last Name: First Name: Preferred Name:

Gender: Gender Identity: Date of Birth: / /

Age: Preferred Language: Phone Number: Email:

Home Address:

Insurance: Insurance #:

Parent/Legal Guardian Information:

Guardian's Name: Relationship to Youth:

(Check preferred method of contact): Main Phone:

Work Phone: Email Address:

Preferred Language:

Referral Information:

Please describe the reasons for referral, including current behaviors, concerns and medical conditions – **OR** – attach to the referral collateral information that describes the client current mental health and behavioral challenges:

Is the adolescent currently receiving mental health services? Yes No

If yes, what services? (Check all that apply)

Counseling Applied Behavioral Analysis (ABA) Psychiatry

Targeted Case Management Other:

Current Mental Health Diagnosis:

Current Mental Health Medications:



Referral Source:

Name: Agency:

Phone Number: Email:

Was youth made aware of this referral? Yes No

Did youth agree to participate? Yes No Unsure

Family Readiness Information

Was the guardian made aware of this referral? Yes No

Does guardian foresee any barriers to attending regular family sessions? Yes No

If yes, please explain why:

Would guardian have any concerns with Bradley REACH team members contacting the youth's school?

Yes No

If yes, please explain why:

Would guardian be willing to work with Bradley REACH team to improve structure and communications in youth's home? Yes No

Is guardian willing to set goals and implement treatment strategies in the home when it is recommended? Yes No

Date of Referral: / /