

Adult Partial Hospitalization Program

EMERGENCY CONTACT AND CURRENT PROVIDERS FORM

Because we take your safety and wellbeing seriously,

1. We will call you if you do not come to the program, and do not call us.
2. We will call your emergency contact person to make sure you are safe if you do not call or come to the program, and do not respond to our call to you.
3. We may request the police department in your area to check on you if we are concerned about your safety when you have not come to the program or called, and we have been unable to confirm that you are safe.

1.) Emergency Contact:	_____
Relationship to Patient:	_____
Address:	_____
Home Phone:	_____
Cell Phone:	_____
Work Phone:	_____

2.) Your Name: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Model/Color of Car: _____

License Plate Number: _____

3.) Therapist Name: _____

Address: _____

Phone: _____

Fax: _____

Date of Last Visit: _____

4.) Psychiatrist Name: _____

Address: _____

Phone: _____

Fax: _____

Date of Last Visit: _____

5.) Primary Care Physician: _____

Address: _____

Phone: _____

Fax: _____

Date of Last Visit: _____