PRP REFERRAL FORM

Fax Number: 443-773-5624

*Please provide a copy of treatment plan at time of referral for goal alignment*

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| **Consumer Information** | |
| **Name:** | **Date of Birth: Age:** |
| **Address:** | **Phone Number:** |
| **MA#:** | **Email:** |
| **Social Security No.:** | **Language: Race:** |
| **School & Grade:** | **Gender: ☐Male or ☐Female** |
| **Parent/Legal Guardian? Check One: ☐ Yes ☐ No** | **Parent/Legal Guardian Name:** |
| **Parent/Legal Guardian Address:** | |
| **DIAGNOSTIC CRITERIA *– (Reflect DSM 5 and ICD-10 codes and descriptions)*** | |
| **Primary Diagnosis (***please include description***):** | |
| **Diagnosis Date:**  **Diagnosis Code 1:**  **Description:**  **Date of Diagnosis:**  **Diagnosis Code 2:**  **Description:**  **Date of Diagnosis:**  **Diagnosis Code 3:**  **Description:**  **Date of Diagnosis:** | |
| **Primary Medical Diagnosis:** | |
| **Diagnosis Code 1:** | |
| **Diagnosis Code 2:** | |
| **Is client prescribed medication?** ☐ Yes ☐ No (*if yes please list below*): | |
| Name: Frequency/Dosage  Name: Frequency/Dosage: | |
| **Socioeconomic/Psychosocial Assessment:** | |
| ☐None ☐Problems w/ Primary Support ☐Housing Problems ☐Problems Related to Social Environment | |
| ☐Financial Problems ☐Educational Problems ☐Legal System ⬜Unknown | |
| **Referral Source Information:** | |
| **Agency Name /Address:** | **Referring Clinician Name:** |
| **Telephone No.:** | **Fax No.:** |
| **Email:** | |
| CLIENT DEMOGRAPHICS AND DETAILS | |
| **Presenting Problems/Behavioral History: (*Detailed behaviors occurring in home, school or community*):**  **Include current critical needs of consumer if applicable (*select all options that apply*)**  ☐Hx of Abuse ☐Hx of Trauma ☐Parent/Caregiver Incarceration  ☐Truancy or Severe School Concerns ☐Current or Past Psychiatric Inpatient or Partial Hospitalizations/Day Programs  ☐Substance Abuse ☐Legal ☐Homelessness | |
| **Previous/Current Services & Hospitalization/Trauma History (*include details & placement history if applicable* ):** | |
| **Service Needs (i.e. identified goals):**  ☐ Self-Care Skills ☐ Legal ☐ Medication Management/Compliance ☐ Social Skills ☐ Health Promotion & Training  ☐Substance Abuse ☐Legal ☐Homelessness ☐ Decision Making Skills ☐ Coping Skills  ☐ Mood/Emotion Regulation ☐ Conflict Resolution Skills ☐ Anger Management ☐ Employment ☐ Family Interaction  ☐ Independent Living Skills ☐ Trauma ☐ Linkeage/Access to Additional Services | |

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| **Identify Treatment Foster Care, Therapeutic Group Home, or facility if applicable:** | |
| Name of Facility: | Ph# ( ) - |
| Address: |  |
| List programs/goals already in place for consumer: | |
| **Current treatment plan goals:** | |
| Consumer’s Current Therapist: |  |
| Referring Clinician Signature (include credentials): | **Date:** |
| Supervisor Name/credentials (PRINTED): |  |
| Supervisor Email: |  |