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/DosageName: 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: |  |