Psychiatric Rehabilitation Referral Form

p 410.863.7213 f 410.863.7205 www.pdgrehab.com
804 Landmark Drive, Suite 118, Glen Burnie, Maryland 21061

Date of Referral: ________________________________

Name: ____ SS#: _____________________________________

DOB: ________________ Sex: ________ Race: _____________ Highest Grade Completed: _______________

Address: ____

City: _____________________________________ ST: ________ Zip: ___________ County: ______________

Phone: (Home) _______________ (Work/Cell) _______________ Caregiver? Yes / No________________

Emergency Contact/Relationship to Consumer: ____

Phone: (Home) ____________________________ (Work/Cell) _____________________________________

Diagnoses: Code(s):

Axis I: ____ _______________ ____________ ___________

Axis II: _______________________________________ _______________ ____________ ___________

Axis III: ______________________________________

Psychosocial Stressor	Severity: None	Mild	Moderate	Severe
Axis IV: Problems in Family Relations	☐	☐	☐	☐
Problems with Friendship/Social Relations	☐	☐	☐	☐
Legal Issues	☐	☐	☐	☐
School/Work Problems	☐	☐	☐	☐
Custody/Placement Problems	☐	☐	☐	☐
Financial Difficulties	☐	☐	☐	☐
Problems with Living Situation	☐	☐	☐	☐
Physical Health	☐	☐	☐	☐

Axis V: Current GAF _____________ Past Year ________

Definition of Problem Areas:

Current Symptoms: ____

Reason for seeking treatment: ____

Risk for Aggressive Behaviors, Suicide, or Homicide (explain): _______________________________________

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Entitlement Info:

SSI $: ________________________________ Date Active: ________________________________

SSDI $: ______________________________ Date Active: ________________________________

Medicaid: ___Medical Assistance ___Qualified Medicare Beneficiary

___Specified Low-Income Medicare Beneficiary

Medicaid or PAC #: __________________________ Date Applied / Active________________________

Medicare #: ___________________________________ Date Applied / Active________________________

Other Income / Insurance: ____

Upon the Doctor's signature below, the consumer being referred is appropriate for Psychiatric Rehabilitation Services provided by Partnership Development Group, Inc.

I, ______________________________________, refer ____
(Physician's Signature) (Print Consumer's Name)

____ ____
(Print Physician's Name) (Physician's Phone Number)

to Partnership Development Group for Psychiatric Rehabilitation Services.