Case Management Referral Form

Anne Arundel & Montgomery Counties, MD
Partnership Development Group
Fax: 410.987.3154

In order to efficiently process referrals, please fill out this form in its entirety, sign, and date.

Date: ___________________ Consumer Name: ____

SS#: ______-_____-______ DOB: _______/_______/_______ Sex: __________ Race: ________________

Street Address: ____

City: __________________________________ State: ______ Zip: ______________ County: ______________________

Phone (Home): ______________________________________ (Work/Mobile): ______________________________________

Physical Description: ____ Highest Grade Completed: __________________

Emergency Contact (Relationship to Consumer):____

Contact's Phone (Home): _____________________ (Work/Mobile): ____________________ Support for Client? Yes / No

Current consumer status (please indicate to assist in the prioritization of referrals):

- ☐ Inpatient- projected release date: ____
- ☐ Partial Hospitalization- projected release date: _______________________________
- ☐ Crisis Bed/Other crisis facility- projected release date: ________________________
- ☐ Outpatient
- ☐ Other: ____

DSM 5 Behavioral Diagnoses:

Code(s)

Primary Behavioral Diagnosis with ICD-10 code (to qualify, primary diagnosis may NOT be substance use disorder or D.D. /intellectual disability)

____

____

DSM 5 Additional Behavioral Diagnosis: ____

____

____

Primary Medical Diagnosis: ____

Social Elements Impacting Diagnosis: (check all that apply)

- ☐ None
- ☐ Problems with access to health care services
- ☐ Housing problems (Not Homelessness)
- ☐ Problems related to social environment
- ☐ Educational problems
- ☐ Problems related to interaction w/legal system/crime
- ☐ Occupational problems
- ☐ Homelessness
- ☐ Financial problems
- ☐ Problems with primary support group
- ☐ Other psychosocial and environmental problems
- ☐ Unknown

Please continue on page 2

Functional Assessment: ____

Definition of Problem Areas (Current Symptoms): ____

____

____

Reason(s) for seeking treatment (check all that apply)**:**

- ☐ Linkage to community resources/community integration
- ☐ Facilitating transition from more intensive services
- ☐ Prevention/reduction of hospitalization or rehospitalization
- ☐ Coordination of current community services
- ☐ Other:____

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

____

Entitlement Information:

SSI monthly: $ ___________________________Date Active: ____________________________

SSDI monthly: $ ___________________________Date Active: ____________________________

Medicaid #: _______________________________Date Applied / Active ______________________

Other Income/Insurance: ____

If consumer does NOT have medical assistance/Medicaid, he or she must meet one or more of the following criteria to qualify for services through Uninsured Eligibility Coverage:

- ☐ Currently homeless or at risk for homelessness
- ☐ Has had an inpatient hospitalization within the last three (3) months
- ☐ Has been incarcerated within the last three (3) months

Upon the clinician's signature below, the consumer being referred is appropriate for psychiatric rehabilitation program services provided by Partnership Development Group, Inc. **This referral must be signed by a physician, nurse practitioner, or independently licensed clinician (LCSW-C or LCPC.)**

I, ____________________________________, refer____

(Clinician's Signature) (Print Consumer's Name)

_______________________________________ _______________________________________

(Print Clinician's Name and **Credentials**) (Clinician's Phone Number)