Psychiatric Rehabilitation Program Referral

Partnership Development Group

Fax: 410.987.3154

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
- ☐ Date of most recent inpatient discharge: _____
- ☐ Other: _____

DSM 5 Behavioral Diagnoses: **Code(s)**

Priority Pop. DSM-5 / ICD-10 Behavioral Diagnosis: (consumer must have one of these diagnoses as primary to qualify for services)

- ☐ 295.90/F20.9 Schizophrenia
- ☐ 295.40/F20.81 Schizophreniform Disorder
- ☐ 295.70/F25.0 Schizoaffective Disorder, Bipolar Type
- ☐ 295.70/F25.1 Schizoaffective Disorder, Depressive Type
- ☐ 298.8/F28 Other Specified Schizophrenia Spectrum or Other Psychotic Disorder
- ☐ 298.9/F29 Unspecified Schizophrenia Spectrum of Other Psychotic Disorder
- ☐ 297.1/F22 Delusional Disorder
- ☐ 296.33/F33.2 Major Depressive Disorder, Recurrent Episode, Severe
- ☐ 296.34/F33.3 Major Depressive Disorder, Recurrent Episode, Severe with Psychotic Features
- ☐ 296.43/F31.13 Bipolar I Disorder, Current or most Recent Episode Manic, Severe
- ☐ 296.44/F31.2 Bipolar I Disorder, Current or most Recent Episode Manic, Severe, with Psychotic Features
- ☐ 296.53/F31.4 Bipolar I Disorder, Current or most Recent Episode Depressed, Severe
- ☐ 296.54/F31.5 Bipolar I Disorder, Current or most Recent Episode Depressed, Severe with Psychotic Features
- ☐ 296.40/F31.0 Bipolar I Disorder, Current or most Recent Episode Hypomanic
- ☐ 296.7/F31.9 Bipolar I Disorder, Unspecified
- ☐ 296.80/F31.9 Unspecified Bipolar and Related Disorder
- ☐ 296.89/F31.81 Bipolar II Disorder,
- ☐ 301.22/F21 Schizotypal Personality Disorder
- ☐ 301.83/F60.3 Borderline Personality Disorder

Additional Behavioral Health Diagnosis: _____

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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

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)