



**Psychiatric Rehabilitation Program Referral**  
 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
- 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
- 296.89/F31.81 Bipolar II Disorder,
- 301.22/F21 Schizotypal Personality Disorder
- 301.83/F60.3 Borderline Personality Disorder

**Additional Behavioral Health Diagnosis:** \_\_\_\_\_

Primary Medical Diagnosis: \_\_\_\_\_

**Social Elements Impacting Diagnosis: (check all that apply)**

- |   |  |
|---|--|
| <input type="checkbox"/> None   | <input type="checkbox"/> Occupational problems                         |
| <input type="checkbox"/> Problems with access to health care services         | <input type="checkbox"/> Homelessness                                  |
| <input type="checkbox"/> Housing problems (Not Homelessness)                  | <input type="checkbox"/> Financial problems                            |
| <input type="checkbox"/> Problems related to social environment               | <input type="checkbox"/> Problems with primary support group           |
| <input type="checkbox"/> Educational problems                                 | <input type="checkbox"/> Other psychosocial and environmental problems |
| <input type="checkbox"/> Problems related to interaction w/legal system/crime | <input type="checkbox"/> 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)