Initial: □ 

Re-Referral: □

**Referral for Psychiatric Rehabilitation Program (Child and Adolescent-PRP)**

**This form must be filled out in its entirety to determine medical necessity and authorization for services.**

**Referral Source Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of person / agency making referral:** |  | **Date:** |  |
| **Address:** |  | | |
| **City/ State/ Zip Code** |  | | |
| **Mental Health Treatment Being Provided** | o Outpatient Mental Health Services  o Inpatient Mental Health Services  o Residential Treatment Center | | |

**Client Information:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client’s name:** |  | **Date of**  **Birth:** |  | **Gender**  **Identification:** |  | | **Race:** |  |
| **Address:** |  | **City, state, zip code** | |  | | | | |
| **Parent/Guardian’s name:** |  | **Relationship to child:** | | o Parent  o Legal Guardian  o Foster Care  Provider | | o DSS  o Other:\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_ | | |
| **Phone number:** |  | **Parent/Guardian’s Email address:** | |  | | | | |
| **Client’s Medicaid #** |  | **Client’s Highest level of education** | |  | | | | |
| **Language(s) spoken in the home:** |  | **Is Interpretation**  **Needed to Speak with Client?** | | o Yes  o No  o Unknown | | | | |
| **Is the participant**  **eligible for fully funded Developmental**  **Disabilities**  **Administration**  **services?\*** | o Yes  o No  o Unknown | **Access to**  **transportation for onsite activities** | | o Yes  o No  o Unknown | | | | |
| **Does this client have a history of**  **substance abuse?** | o Yes  o No  o Unknown | **Does client have a history of gambling?** | | o Yes  o No  o Unknown | | | | |

**Synergy Family Services, Inc.**

1425 University Blvd, Suite 265, Hyattsville, Maryland 20783-

Office: 240-752-2767-Fax: 301-326-4835

prpreferrals@synergyfamilyservices.org



|  |  |  |  |
| --- | --- | --- | --- |
| **The youth has been engaged in active, documented**  **outpatient treatment for:\*\***  **Current frequency of treatment provided: (How often does**  **clinician meet with client?)** | o Less than 1  month  o Between 1-3  months  o 6 months or  more  o 12 months or  more  o More than once  a week  o Weekly  o Biweekly  o Monthly | **In the past three**  **months, how many ER visits has the**  **youth had for**  **psychiatric care?\***  **Has medication been considered for this youth? If yes, what medication is youth taking?** | o No visits in the last 3 months  o One visit in the last 3 months  o 2 or more visits in the last 3 months  o Yes  o No |

**PRP may not routinely be provided in conjunction with:**

**- Mobile Treatment Services (MTS)/Assertive Community Treatment (ACT)**

**- Targeted Case Management (TCM)**

**- Inpatient Psychiatric Services**

**- Crisis Residential Services**

**- Psychiatric Residential Treatment Facility (PRTF)/ Residential Treatment Center (RTC)**

**- Mental Health- Intensive Outpatient Program (IOP)**

**- Mental Health- Partial Hospitalization Program (PHP)**

**- Respite**

**- Therapeutic Behavioral Services (TBS)**

**- Residential Substance Use Disorder Treatment Level 3.3 or higher**

**- Substance Use Disorder-Intensive Outpatient Program (IOP)**

**- Substance Use Disorder- Partial Hospitalization Program (PHP)**

**Is the youth currently in treatment or receiving services from any of the services listed above: \_\_\_\_\_\_Yes \_\_\_\_\_\_no Has a crisis plan been completed with family and/or guardian? \_\_\_\_ Yes \_\_\_\_No**

**REASON FOR REFERRAL:** *(Indicate the areas you want the PRP to address.)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Requested Services (Check all that apply)** | | | | |
| **Self-Care Skills** Hygiene  o Nutrition  o P h y s i c a l Health  o P e r s o n a l safety | **Social Skills**  o Developing supports o Conflict resolution o Boundary awareness o C o m m u n i c a t i o n skills | **Independent Living Skills**  o Money management  o Maintaining living env’t  o Cooking/Shopping  o Time management | **Community Resources Coordination**  o I d e n t i f y i n g resources  o E n t i t l e m e n t Application  o H o u s i n g Coordination  o Vocational/Job Skill | **Symptom Management** o Psychoeducation  o Coping skill  development  o Mental health  education  o Emotional Regulation |
| **ICD-10 Primary Diagnosis Code:**  **A minor must have a behavioral diagnosis and be referred by a Licensed MH Professional to be eligible for PRP.** | | | | |

**Synergy Family Services, Inc.**

1425 University Blvd, Suite 265, Hyattsville, Maryland 20783-

Office: 240-752-2767-Fax: 301-326-4835

prpreferrals@synergyfamilyservices.org



|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Primary Behavioral**  **Diagnosis code and**  **description:** |  | | | | |
| **Secondary Behavioral**  **Diagnosis code and**  **description:** |  | | | | |
| **Diagnosis given by:** | o Referring Clinician | | o Other:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Social Elements Impacting Diagnoses:**  **(Required)** | o None  o Unknown  o Other:  \_\_\_\_\_\_\_\_ | o Housing  o Homelessness  o Social  Environmental  l | | o Educational  o Primary  support  o Occupational | o Financial  o Access to  Healthcare  o Legal  System |

|  |  |  |
| --- | --- | --- |
| **Functional Criteria (please provide explanation)**  **Within the past three months, the individual's emotional disturbance has resulted in:\* Please note: One of the below three must be “Yes” in order to refer for PRP.** | | |
| **A clear, current threat to the youth's ability to be maintained in their customary setting?\*\*** | **Yes No** | **No** |
| *If yes, explain:* | | |
| **An emerging risk to the safety of the youth or others?\*\*** | **Yes No** | **No** |
| *If yes, explain:* | | |
| **Significant psychological or social impairments causing serious problems with peer relationships and/or family members? \*\*Please discuss symptoms (frequency, severity, as well as impairments, and examples of behaviors/impairments and the impact on client’s independent living skills as it relates to home, school, and in the community.** | **Yes No** | **No** |
| *If yes, explain:* | | |
| **What evidence exists to show that the current intensity of outpatient treatment for this individual is insufficient to reduce the youth's symptoms and functional behavioral impairments resulting from mental illness?\* Please discuss previous mental health history, psychiatric services/medication considerations, and symptoms and why therapy itself is not enough to help client with his impairments.** | | |

**Synergy Family Services, Inc.**

1425 University Blvd, Suite 265, Hyattsville, Maryland 20783-

Office: 240-752-2767-Fax: 301-326-4835

prpreferrals@synergyfamilyservices.org



|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Explain:* | | |  |  |
| **Has the youth made progress toward age appropriate development, more independent functioning and independent living skills?\*\* (For reauthorizations ONLY)** | **Yes No** | **No** |  |  |
| *Explain:* | | |  |  |
|  | | |  |  |
|  |  |  |  |  |

**Mental Health Practitioner:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Print Name:** |  | **Date of referral** |  |
| **Signature, with**  **credentials** |  | **Phone number:** |  |
| **Email address:** |  |
| ***Clinical supervisor, as applicable:*** |  |  |  |

Please include copies of the following:

o *Most recent psychiatric evaluation, as applicable*

o *Most recent biopsychosocial assessment, as applicable*

o *Records of Medication, as applicable*

**Synergy Family Services, Inc.**

1425 University Blvd, Suite 265, Hyattsville, Maryland 20783-

Office: 240-752-2767-Fax: 301-326-4835

prpreferrals@synergyfamilyservices.org