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 |

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|  |  |  |  |
| --- | --- | --- | --- |
| **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.)*

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| --- |
| **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.** |

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|  |  |
| --- | --- |
| **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.** |

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|  |  |  |
| --- | --- | --- |
| *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*

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