**Referral for Psychiatric Rehabilitation Program (Adult-PRP)**

Initial: □

Re-Referral: □

**Referral Source Information:**

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

**Consumer Information:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name:** |  | **Date of Birth:** |  | **Age:** |  | |
| **Address:** |  | **Social Security #:** |  | **Sex:** | Male  Female | |
| **City, State, Zip:** |  | **Medical Assistance #:** |  | | | |
| **Phone #:** |  | **Access to Transportation for On Site Activities:** | | | | Yes  No |

This form must be filled out in its entirety in order to allow for medical necessity and authorization for services. Please do not add diagnoses to the form.

**Behavioral Diagnoses**

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

**Primary Medical Diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Social Elements Impacting Diagnosis**

|  |  |  |  |
| --- | --- | --- | --- |
| None | Access to Health Care | Housing Problems | Social Environment |
| Educational | Legal System/Crime | Occupational | Homelessness |
| Financial | Primary Support | Other Psychosocial/Enviro. | Unknown |

**This individual has a serious mental illness which has required the intervention of the Public Mental Health System in the last two years:**

**Yes** **No**

**Individual experiences at least three of the following:**

Inability to maintain independent employment

Social behavior that results in interventions by the mental health system

Inability to procure financial assistance due to cognitive disorganization

Severe inability to establish or maintain social supports

Need or assistance with basic living skills

Current Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the individual med compliant: yes no

**Presenting Symptoms: Please include hx of Severity of Illness and History of Illness**

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**Criminal History-** yes no

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

1. **Self-care skills-** personal hygiene, grooming, nutrition, dietary planning, food preparation, self administration of medication.
2. **Social Skills-** community integration activities, developing natural supports, developing linkages with and supporting the individual’s participation in community activities.
3. **Independent living skills-** skills necessary for housing stability, community awareness, mobility and transportation skills, money management, accessing available entitlements and resources, supporting the individual to obtain and retain employment, Health promotion and training, individual wellness self management and recovery.

**Mental Health Practitioner:**

|  |  |
| --- | --- |
| Name: | Date: |
| Signature: | Date: |

***Attach a “Professional Assertion of Need for PRP Services” , copy of the current Treatment Plan, current Psychiatric Evaluation, Current Crisis Plan-if client is at risk for suicide, homicide or runaway status, If client is in Foster care or in DSS custody please provide copy of court papers showing guardianship***

|  |
| --- |
| *PRP Staff:* Date Referral, Assertion of Need & Tx Plan Received*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Screening Scheduled within 5 days?: \_\_\_\_ Yes \_\_\_\_\_ No |