**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 |