SYNERGY
FAMILY SERVICES, INC.

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	○ Outpatient Mental Health Services ○ Inpatient Mental Health Services ○ 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:**	○ Parent ○ Legal Guardian ○ Foster Care Provider	○ DSS ○ 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?**	○ Yes ○ No ○ Unknown		
Is the participant eligible for fully funded Developmental Disabilities Administration services?*	○ Yes ○ No ○ Unknown	**Access to transportation for onsite activities**	○ Yes ○ No ○ Unknown		
Does this client have a history of substance abuse?	○ Yes ○ No ○ Unknown	**Does client have a history of gambling?**	○ Yes ○ No ○ Unknown		
The youth has been engaged in active, documented outpatient treatment for:**	○ Less than 1 month ○ Between 1-3 months ○ 6 months or more ○ 12 months or more	**In the past three months, how many ER visits has the youth had for psychiatric care?***	○ No visits in the last 3 months ○ One visit in the last 3 months ○ 2 or more visits in the last 3 months		
Current frequency of treatment provided: (How often does clinician meet with	○ More than once a week ○ Weeky ○ Biweekly	**Has medication been considered for this youth?**	○ Yes ○ No		

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client?)	○ Monthly		

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 ○ Nutrition ○ Physical Health ○ Personal safety	**Social Skills** ○ Developing supports ○ Conflict resolution ○ Boundary awareness ○ Communication skills	**Independent Living Skills** ○ Money management ○ Maintaining living env't ○ Cooking/Shopping ○ Time management	**Community Resources Coordination** ○ Identifying resources ○ Entitlement Application ○ Housing Coordination ○ Vocational/Job Skill	**Symptom Management** ○ Psychoeducation ○ Coping skill development ○ Mental health education ○ 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.**				
Primary Behavioral Diagnosis code and description:				
Secondary Behavioral Diagnosis code and description:				
Diagnosis given by:	○ Referring Clinician	○ Other: _____		
Social Elements Impacting Diagnoses: **(Required)**	○ None ○ Unknown ○ Other: _____	○ Housing ○ Homelessness ○ Social Environmental	○ Educational ○ Primary support ○ Occupational	○ Financial ○ Access to Healthcare ○ 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**
If yes, explain:		

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An emerging risk to the safety of the youth or others?**	**Yes**	**No**
If yes, explain:		
Significant psychological or social impairments causing serious problems with peer relationships and/or family members?**	**Yes**	**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 (frequency, severity, and duration) and the impact on client's independent living skills as it relates to home, school, and in the community.		
Explain:		
Has the youth made progress toward age appropriate development, more independent functioning and independent living skills? (For reauthorizations ONLY)**	**Yes**	**No**
Explain:		
How will PRP serve to help this youth get to age appropriate development, more independent functioning, and independent living skills?		
Explain:	**Yes**	**No**

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:

- *Most recent psychiatric evaluation, as applicable*
- *Most recent biopsychosocial assessment, as applicable*

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- *Records of Medication, as applicable*

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