Psychiatric Rehabilitation Program Referral

Partnership Development Group

Fax: 410.987.3154

Partnership Development Group

Fostering community integration for individuals with disabilities

To efficiently process referrals, please fill out this form in its entirety, sign, and date.

Date: _____/_____/_____ Consumer Name: _____

SS#: _____-_____-_____ DOB: _____/_____/_____ Gender: _____ Race: _____

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____

Physical Description: _____ Highest Grade Completed: _____

Emergency Contact (Relationship to Consumer):_____

Contact's Phone: _____

Current consumer status (please indicate to assist in the prioritization of referrals):

- ☐ Inpatient- projected release date: _____
- ☐ Partial Hospitalization- projected release date: _____
- ☐ Crisis Bed/Other crisis facility- projected release date: _____
- ☐ Outpatient
- ☐ Date of most recent inpatient discharge: _____
- ☐ Other: _____

DSM 5 Behavioral Diagnoses: (choose only one)

Priority Pop. DSM-5 / ICD-10 Behavioral Diagnosis: (consumer must have one of these diagnoses as primary to qualify for services)

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

Additional Behavioral Health Diagnosis: _____

_____

Anne Arundel County
1110 Benfield Blvd.
Suite B
Millersville, MD 21108

Baltimore City
1401 Severn Street
Suite 201
Baltimore, MD 21230

Montgomery County
7529 Standish Place
Suite 103
Rockville, MD 20855

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Please continue page 2

Primary Medical Diagnosis: _____

Social Elements Impacting Diagnosis: (check all that apply)

- ☐ None
- ☐ Problems with access to health care services
- ☐ Housing problems (Not Homelessness)
- ☐ Problems related to social environment
- ☐ Educational problems
- ☐ Problems related to interaction w/legal system/crime
- ☐ Occupational problems
- ☐ Homelessness
- ☐ Financial problems
- ☐ Problems with primary support group
- ☐ Other psychosocial and environmental problems
- ☐ Unknown

Functional Assessment: _____

Definition of Problem Areas (Current Symptoms): _____

_____

Reason(s) for seeking treatment (check all that apply):

- ☐ Linkage to community resources/community integration
- ☐ Facilitating transition from more intensive services
- ☐ Prevention/reduction of hospitalization or rehospitalization
- ☐ Coordination of current community services

Risk for Aggressive Behaviors, Suicide, or Homicide: (explain): _____

_____

Entitlement Information:

SSI monthly: $ _____Date Active: _____

SSDI monthly: $ _____Date Active: _____

Medicaid #: _____Date Applied / Active _____

Other Income/Insurance: _____

Upon the clinician's signature below, the consumer being referred is appropriate for psychiatric rehabilitation program services provided by Partnership Development Group, Inc. **This referral must be signed by a physician, nurse practitioner, or independently licensed clinician (LCSW-C or LCPC.)**

I, _____, refer_____

(Clinician's Signature) (Print Consumer's Name)

_____ _____

(Print Clinician's Name and **Credentials**) (Clinician's Phone Number)

Referring Agency: _____