

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

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

Additional Behavioral Health Diagnosis: _____

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E info@pdgrehab.com
pdgrehab.com

Primary Medical Diagnosis: _____

Social Elements Impacting Diagnosis: (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Occupational problems |
| <input type="checkbox"/> Problems with access to health care services | <input type="checkbox"/> Homelessness |
| <input type="checkbox"/> Housing problems (Not Homelessness) | <input type="checkbox"/> Financial problems |
| <input type="checkbox"/> Problems related to social environment | <input type="checkbox"/> Problems with primary support group |
| <input type="checkbox"/> Educational problems | <input type="checkbox"/> Other psychosocial and environmental problems |
| <input type="checkbox"/> Problems related to interaction w/legal system/crime | <input type="checkbox"/> Unknown |

Functional Assessment: _____

Definition of Problem Areas (Current Symptoms): _____

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

- | | |
|---|---|
| <input type="checkbox"/> Linkage to community resources/community integration | <input type="checkbox"/> Prevention/reduction of hospitalization or rehospitalization |
| <input type="checkbox"/> Facilitating transition from more intensive services | <input type="checkbox"/> 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) (Date MM/DD/YY) (Print Consumer's Name)

(Print Clinician's Name and Credentials)

(Clinician's Phone Number)

Referring Agency: _____