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

Consumer Name: _____

SS#: _____ DOB: _____ Gender: _____ Race: _____

Street Address: _____

City: _____ State: ____ Zip _____ County: _____

Consumer's 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 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: _____

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 **doctor's or licensed clinician's signature and credentials** below, I attest that I am enrolled with Medicaid and eligible to refer clients to PRP services in accordance with state and federal regulations under COMAR 10.09.59.05B-C and 42 CFR § 455.410. This 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) (Consumer's Name)

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

Date: _____

Referring Agency: _____