Psychiatric Rehabilitation Program (PRP) Referral Form –Adults

Please fax the referral to (443)-859-8880 or email it to PRPMD@lead4lifeinc.org

☐ BALTIMORE CITY ☐ EASTERN SHORE ☐ FREDERICK COUNTY ☐ MONTGOMERY COUNTY ☐ WASHINGTON D.C METROPOLITAN AREA

REFERRAL DATE: ____________________ HOW DID YOU HEAR ABOUT PRP?______________________________________

CLIENT NAME : ____ DATE OF BIRTH: ____________________

GENDER: ______________ RACE: __________________ ETHNICITY: ☐HISPANIC/LATINO ☐NOT HISPANIC/LATINO

ADDRESS:____

____

PHONE : ____ E MAIL: ____

MEDICAL ASSISTANCE NUMBER : ____

EMERGENCY CONTACT: ____ RELATIONSHIP TO CLIENT: ___________________

ADDRESS: ____

PHONE: ____________________________________ EMAIL: ____

LIVING SITUATION / CONDITION

☐ PRIVATE RESIDENCE ☐ FOSTER HOME ☐ RESIDENTIAL FACILITY ☐ CRISIS RESIDENCE ☐ CORRECTIONAL FACILITY

☐ INPATIENT FACILITY ☐ GROUP HOME ☐ HOMELESS SHELTER ☐ OTHER _________________________________

PREGNANT

☐ YES DUE DATE:__________ ☐ NO ☐ NOT APPLICABLE

MILITARY SERVICE

☐ YES ☐ NO TIME SERVED: __________________

MARITAL STATUS

☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOW/WIDOWER ☐ NOT AVAILABLE

HIGHEST LEVEL OF SCHOOL COMPLETED: ____

IS THE INDIVIDUAL CURRENTLY PARTICIPATING IN ANY OF THE FOLLOWING:

☐ MOBILE TREATMENT SERVICES

☐ ASSERTIVE COMMUNITY TREATMENT (ACT)

☐ ADULT TARGETED CASE MANAGEMENT (TCM)

☐ INPATIENT

☐ METAL HEALTH -RESIDENTIAL TREATMENT CENTER (RTC)

☐ RESIDENTIAL SUD TREATMENT LEVEL 3.3 AND HIGHER

☐ SUBSTANCE USE DISORDER INTENSIVE OUTPATIENT/2.1

☐ MENTAL HEALTH INTENSIVE OUTPATIENT / PARTIAL HOSPITALIZATION PROGRAM

☐ RESIDENTIAL CRISIS

DSM BEHAVIORAL DIAGNOSES: CATEGORY A

(AT LEAST ONE DIAGNOSIS MUST BE SELECTED; SELECT NUMBER 1 OR 2):

PRIORITY POPULATION DSM-5/ICD-10 BEHAVIORAL DIAGNOSES: CLIENT MUST HAVE ONE OF THESE DIAGNOSES AS A PRIMARY TO BE ELIGIBLE FOR SERVICES - **CATEGORY A**

- ☐ **F20.1/295.10-SCHIZOPHRENIA, DISORGANIZED**
- ☐ **F20.2/295.20-SCHIZOPHRENIA, CATATONIC**
- ☐ **F20.0/295.30- SCHIZOPHRENIA, PARANOID**
- ☐ **F20.81/295.40-SCHIZOPHRENIFROM DISORDER**
- ☐ **F25.0/295.70-SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE**
- ☐ **F25.1/295.70-SCHIZOAFFECTIVE DISORDER, DEPRESSIVE TYPE**
- ☐ **F33.3/296.34-Major Depressive Disorder, Recurrent Episode WITH PSYCHOTIC FEATURES**
- ☐ **F31.2/296.44-BIPOLAR I, MOST RECENT MANIC, WITH PSYCHOTIC FEATURES**
- ☐ **F31. / - BIPOLAR 1, RECURRENT, SEVERE, WITH PSYCHOTIC FEATURES**
- ☐ **F31.5/296.54-BIPOLAR I, MOST RECENT EPISODE DEPRESSED WITH PSYCHOTIC FEATURES**
- ☐ **F31. / - BIPOLAR 1 DISORDER, RECURRENT EPISODE DEPRESSED, SEVERE, WITH PSYCHOTIC FEATURES**
- ☐ **OTHER SPECIFIED SCHIZOPHRENIA SPECTRUM DISORDER**
- ☐ **OTHER SPECIFICED PSYCHOTIC DISORDER**
- ☐ **UNSPECIFIED SCHIZOPHRENIA SPECTRUM DISORDER**
- ☐ **UNSPECIFIED PSYCHOTIC DISORDER**
- ☐ **F22/297.10- DELUSIONAL DISORDER**

☐ **HAS THE INDIVIDUAL FOUND TO BE NON-COMPETENT TO STAND TRIAL OR NOT CRIMINALLY RESPONSIBLE DUE TO A MENTAL DISORDER PURSUANT TO CRIMINAL PROCEDURE?**

☐ **IS THE CLIENT AN INDIVIDUAL IN A MARYLAND STATE PSYCHIATRIC FACILITY WITH A LENGTH OF STAY OR MORE THAN 3 MONTHS WHO REQUIRES RESIDENTIAL REHABILITATION PROGRAM (RRP) SERVICES UPON DISCHARGE?**

☐ **1. THE INDIVIDUAL IS CURRENTLY ENROLLED IN SSI OR SSDI**

☐ **2. THE INDIVIDUAL DEMONSTRATES IMPAIRED ROLE FUNCTIONING FOR AT LEAST TWO YEARS IN THREE OF THE FOLLOWING CATEGORIES:**

- ☐ **a. MARKED INABILITY TO ESTABLISH OR MAINTAIN INDEPENDENT COMPETITIVE EMPLOYMENT**
  Must Document Clinical Evidence:

- ☐ **b. MARKED INABILITY TO ESTABLISH OR MAINTAIN PERSONAL SUPPORT SYSTEM**
  Must Document Clinical Evidence:

- ☐ **c. MARKED OR FREQUENT DEFICIENCIES OF CONCENTRATION, PERSISTENCE OR PACE**
  Must Document Clinical Evidence:

- ☐ **d. MARKED INABILITY TO PERFORM OR MAINTAIN SELF-CARE**
  Must Document Clinical Evidence:

- ☐ **e. MARKED DEFICIENCIES IN SELF-DIRECTION**
  Must Document Clinical Evidence:

☐ f. MARKED INABILITY TO PROCURE FINANCIAL ASSISTANCE TO SUPPORT COMMUNITY LIVING
<u>**Must Document Clinical Evidence:**</u>

DSM BEHAVIORAL DIAGNOSES: CATEGORY B

(AT LEAST ONE DIAGNOSIS MUST BE SELECTED AND QUESTION ONE MUST BE TRUE FOR THE INDIVIDUAL):

☐ **F33.2/296.33-Major Depressive Disorder, CURRENT EPISODE, SEVERE W/O PSYCHOSIS**

☐ **F31.13/296.43-BIPOLAR I DISORDER, MOST RECENT MANIC, SEVERE**

☐ **F31.13/296.43-BIPOLAR I DISORDER, MOST RECENT, DEPRESSED, SEVERE**

☐ **F31.13/296.43-BIPOLAR I DISORDER, MOST RECENT HYPOMANIC**

☐ **F31.13/296.43-BIPOLAR I DISORDER, MOST RECENT, UNSPECIFIED**

☐ **F31.81/296.89-BIPOLAR II DISORDER**

☐ **F31. / 296. – BIPOLAR 1 DISORDER, CURRENT, MANIC, SEVERE**

☐ **F31. / 296. – BIPOLAR 1 DISORDER, CURRENT, DEPRESSED, SEVERE**

☐ **F31. / 296. – BIPOLAR 1 DISORDER, CURRENT, HYPOMANIC**

☐ **F31. / 296. – BIPOLAR 1 DISORDER, UNSPECIFIED**

☐ **F60.3/301.83- BORDERLINE PERSONALITY DISORDER**

☐ **1. THE INDIVIDUAL DEMONSTRATES IMPAIRED ROLE FUNCTIONING FOR AT LEAST TWO YEARS IN <u>THREE</u> OF THE FOLLOWING CATEGORIES:**

☐ **a. MARKED INABILITY TO ESTABLISH OR MAINTAIN INDEPENDENT COMPETITIVE EMPLOYMENT**
<u>**Must Document Clinical Evidence:**</u>

☐ **b. MARKED INABILITY TO ESTABLISH OR MAINTAIN PERSONAL SUPPORT SYSTEM**
<u>**Must Document Clinical Evidence:**</u>

☐ **c. MARKED OR FREQUENT DEFICIENCIES OF CONCENTRATION, PERSISTENCE OR PACE**
<u>**Must Document Clinical Evidence:**</u>

☐ **d. MARKED INABILITY TO PERFORM OR MAINTAIN SELF-CARE**
<u>**Must Document Clinical Evidence:**</u>

☐ **e. MARKED DEFICIENCIES IN SELF-DIRECTION**
<u>**Must Document Clinical Evidence:**</u>

☐ **f. MARKED INABILITY TO PROCURE FINANCIAL ASSISTANCE TO SUPPORT COMMUNITY LIVING**
<u>**Must Document Clinical Evidence:**</u>

SOCIAL ELEMENTS IMPACTING DIAGNOSIS: ***(CHECK ALL THAT APPLY)***

- ☐ NONE
- ☐ PROBLEMS WITH ACCESS TO HEALTH CARE SERVICES
- ☐ HOUSING PROBLEMS (NOT HOMELESS)
- ☐ PROBLEMS RELATED TO SOCIAL ENVIRONMENT
- ☐ EDUCATIONAL PROBLEMS
- ☐ PROBLEMS RELATED TO INTERACTION W/LEGAL SYSTEM
- ☐ OCCUPATIONAL PROBLEMS
- ☐ HOMELESSNESS
- ☐ FINANCIAL PROBLEMS
- ☐ PROBLEMS WITH PRIMARY SUPPORT GROUP
- ☐ OTHER PSYCHOLOGICAL AND ENVIRONMENTAL PROBLEMS
- ☐ UNKNOWN

REASON FOR REFERRAL ***(CHECK ALL THAT APPLY):***

☐ EMOTIONAL/MENTAL ILLNESS ☐ EMPLOYMENT INSTABILITY ☐ FINANCIAL INSTABILITY/DIFFICULTY ☐ CPS INVOLVED

☐ BEHAVIOR/CONDUCT PROBLEMS ☐ LEGAL/INCARCERATION ☐ MEDICATION MISMANAGEMENT/MONITORING

☐ PHYSICAL/EMOTIONAL ABUSE ☐ RELATIONAL CONFLICTS ☐ SEXUAL ABUSE ☐ SOCIAL/INTERPERSONAL CHALLENGES

☐ SUBSTANCE ABUSE ☐ SUICIDAL/HOMICIDAL ☐ SCHOOL PROBLEM/SUSPENSION ☐ HOMELESSNESS/AT RISK OF HOMELESSNESS

PRP SERVICES REQUESTED ***(CHECK ALL THAT APPLY):***

SELF-CARE SKILLS:

☐ PERSONAL HYGIENE ☐ GROOMING ☐ NUTRITION ☐ DIETARY PLANNING

☐ FOOD PREPARATION ☐ SELF-ADMINISTRATION OF MEDICATION

SOCIAL SKILLS:

☐ COMMUNITY INTEGRATION ACTIVITIES ☐ DEVELOPING NATURAL SUPPORTS

☐ DEVELOPING LINKAGES WITH AND SUPPORTING THE INDIVIDUAL'S PARTICIPATION IN COMMUNITY ACTIVITIES.

INDEPENDENT LIVING SKILLS:

☐ SKILLS NECESSARY FOR HOUSING STABILITY ☐ COMMUNITY AWARENESS ☐ MOBILITY AND TRANSPORTATION SKILLS

☐ MONEY MANAGEMENT ☐ ACCESSING AVAILABLE ENTITLEMENTS AND RESOURCES

☐ HEALTH PROMOTION AND TRAINING ☐ SUPPORTING THE INDIVIDUAL TO OBTAIN AND RETAIN EMPLOYMENT

☐ INDIVIDUAL WELLNESS SELF-MANAGEMENT AND RECOVERY

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

OTHER: ____

LINKED PROVIDERS

PSYCHIATRIST: ________________________________ PHONE NUMBER:____________________

THERAPIST: __________________________________ PHONE NUMBER:____________________

PRIMARY CARE PROVIDER: _________________________ PHONE NUMBER : ____________________

MEDICAL NECESSITY CRITERIA (SELECT ALL THAT APPLY)

THE PARTICIPANT'S MENTAL ILLNESS IS THE CAUSE OF SERIOUS DYSFUNCTION IN ONE OR MORE LIFE DOMAINS,

☐ HOME _ ☐ SCHOOL ☐ COMMUNITY

SYMPTOMS AND BEHAVIOR/RISK BEHAVIORS *(CHECK ALL THAT APPLY)*:

☐ ANXIETY/PANIC ☐ ATTACHMENT PROBLEMS ☐ DEPRESSED ☐ FIRE SETTING ☐ HOMICIDAL IDEATIONS
☐ HOPELESS/HELPLESS ☐ HYPERACTIVE ☐ IMPULSIVE ☐ IRRITABLE ☐ ISOLATIVE ☐ LYING/MANIPULATIVE
☐ MANIC MOOD ☐ OBSESSION/COMPULSION ☐ OPPOSITIONAL DEFIANT ☐ PHYSICAL AGGRESSION
☐ PROPERTY DESTRUCTION ☐ RUNNING AWAY ☐ SELF-CARE DEFICIT ☐ SELF-INJURIOUS BEHAVIOR
☐ SEPARATION PROBLEMS ☐ SEXUALLY INAPPROPRIATE ☐ SOCIAL/WITHDRAWAL ☐ STEALING ☐ SUICIDAL IDEATIONS
☐ TRAUMA-RELATED ☐ TRUANCY ☐ VERBAL AGGRESSION ☐ OTHER

PRP CRITERIA- ADULT

☐ THE NATURE OF THE INDIVIDUAL'S FUNCTIONAL IMPAIRMENTS AND/OR SKILLS DEFICITS CAN BE EFFECTIVELY REMEDIATED THROUGH SPECIFIC, FOCUSED SKILLS-TRAINING ACTIVITIES DESIGNED TO DEVELOP AND RESTORE OR MAINTAIN INDEPENDENT LIVING SKILLS TO SUPPORT THE INDIVIDUALS RECOVERY

☐ THE INDIVIDUAL IS CURRENTLY ENGAGED IN OUTPATIENT MENTAL HEALTH TREATMENT

.☐ RESIDES IN A RRP (NOT REQUIRED FOR ALL INDIVIDUALS)

☐ THE INDIVIDUAL DOES NOT REQUIRE A MORE INTENSIVE LEVEL OF CARE.

☐ ALL LESS INTENSIVE LEVELS OF TREATMENT HAVE BEEN DETERMINED TO BE UNSAFE OR UNSUCCESSFUL

☐ PEER OR NATURAL SUPPORT ALTERNATIVES HAVE BEEN CONSIDERED OR ATTEMPTED, AND/OR ARE SUFFICFICENT TO MEET THE NEED FOR SPECIFIC, FOCUSED SKILLS TRAINING TO FUNCTION EFFECTIVELY.

REASON FOR REFERRALS (NARRATIVE – PLEASE PROVIDE CLINICAL JUSTIFICATION):

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____

THERAPIST'S NAME: ____ CREDENTIALS: ____________________________

CONTACT NUMBER: ___________________________________ EMAIL: ____

ADDRESS:____

THERAPIST'S SIGNATURE: ____

L4L USE ONLY

DATE RECEIVED:____________________________FACILITY:____

REFERRAL ACCEPTED ____________________________ DATE OF INITIAL APPOINTMENT___________________________

REFERRAL DENIED ______________________________REASON____

REFERRAL STATUS COMMUNICATED TO ____ DATE _________________

INSURANCE AUTHORIZATION NUMBER____

NUMBER OF AUTHORIZATION VISITS ____

DATES OF AUTHORIZATION FROM: _________________________ TO: ______________________________________

SCHEDULED DIAGNOSTIC INTERVIEW _____ YES _____ NO DATE: ___________ THERAPIST: __________________________

DATE ASSIGNED: ____________________ COUNSELOR: ____

COMMENTS:

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