Psychiatric Rehabilitation Program

Referral Form

Date of Referral: _____ Medical Assistance #: _____

Client Name: _____ Date of Birth: _____ Age: _____

Gender: _____ Race/Ethnicity: _____ School: _____Grade: _____

Address: _____Phone Number: _____

Pregnant: □ Yes □ No Military Services: □ Yes □ No Living Situation: _____

Emergency Contact:

Parent/Guardian: _____ Relationship: _____ Phone #:_____

Parent/Guardian: _____Relationship: _____Phone #: _____

Address if not the same as above: _____

REASON FOR REFERRAL (*check all that apply):*

- ☐ Emotional/Mental Illness
- ☐ Behavior/Conduct Problems
- ☐ Physical/Emotional Abuse
- ☐ Social/Interpersonal Challenges
- □ Relational Conflicts
- □ Legal/Criminal Issues
- □ School Problem/Suspension
- □ Other psychosocial and environmental problem

Diagnosis: please indicate current ICD-10 codes:

_____ _____

_____ _____

The impairment as a result of the participant's mental illness:	Yes	No
A clear, current threat to the participant's ability to be maintained in his/her customary setting		
An emerging/pending risk to the safety of the participant and others		
Others evidence of significant psychological or social impairments, such as inappropriate social behavior, causing serious problems with peer relationships and/or family members		
The participant, due to the dysfunction, is at-risk for requiring higher level of care, or is returning from a higher level of care		
The participant's condition requires an integrated program of rehabilitation services to develop and restore independent living skills to support the participant's recovery		
The participant does not require a more intensive level of care and is judged to be in enough behavioral control to be safe in the rehabilitation program and benefit from the rehabilitation provided.		
For participant transition from an inpatient, day hospital, or residential treatment setting to a community setting; there is evidence that PRP services will be necessary to prevent clinical deterioration and support successful transition back to the community, or avert the need to initiate or continue a more intensive level of care.		

THE PERSONAL WELLNESS CENTER
mind • body • spirit

Psychiatric Rehabilitation Program

Referral Form

List of Medications/Known Allergies (NONE □)		
Type	**Dosage/Frequency**	**Prescribed by:**

REHABILITATION SERVICES NEEDED (*check all that apply):*

Self-Care Skills: □ Personal Hygiene □ Grooming □ Nutrition
□ Dietary Planning □ Food Preparation □ Physical Health
□ Self- Administration of Medication □ Maintain Personal Living Space
□ Maintain Personal safety

Social Skills: □ Community Integration Activities □ Developing Natural Supports
□ Mindful Coping Strategies □ Assertiveness/Self Esteem
□ Age Appropriate Boundaries □ Anger Management and Conflict Resolution
□ Interaction skills with Peers and Authority Figures

Independent Living Skills: □ Health Promotion and Training □ Community Awareness
□ Time Management □ Mindful Activities of Daily Living
□ Individual Wellness Self-Management and Recovery

Is the child/adolescent group appropriate: □ Yes □ No

Clinical Rationale:

_____ _____
Clinical Therapist Signature **Date**

PRP USE ONLY

Date Referral Received: _____ **Date of Collaboration with Therapist:** _____

Date Client Contacted: _____ **Optum Incedo Authorization Date:** _____