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 □ Relational Conflicts □ Physical/Emotional Abuse

□ Behavior/Conduct Problems □ Legal/Criminal Issues □ School Problem/Suspension

□ Social/Interpersonal Challenges □ Other psychosocial and environmental problem

Current Diagnosis: ICD-10 codes Only:

Primary :___________________________ Secondary:__________________________________

Diagnosing Clinician ____

Clinician Title and Credentials ______________________ **Clinician Agency** _________________

Medication	Dosage/per day	Prescribing Doctor

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Primary clinical treatment provider:

Name: ______________________________________ Credential_________________

Agency: _____________________________________

Additional clinical treatment providers:

Name: ______________________________________ Credential_________________

Agency: _____________________________________

Name: ______________________________________ Credential_________________

Agency: _____________________________________

Current frequency of treatment provided to this individual?

☐ At least 1x/week ☐ At least 1x/2 weeks ☐ At least 1x/month ☐ At least 1x/3 months ☐ At least 1x/6 months

How long has youth been engaged in active, documented outpatient treatment?

☐ Less than 1 month ☐ 2-3 three months ☐ 4-6 months ☐ 7-12 months ☐ more than 12 months

In the past 3 months, how many visits to the ER has the youth had for psychiatric care?

☐ No visits in the last 3 months ☐ 1 visit in the last 3 months ☐ More than 2 visits in the last 3 months

Is the youth transitioning from inpatient, day treatment or residential facility to a community setting**?** ☐ Yes ☐ No

Does the youth have a Target Case Management referral or authorization? ☐ Yes ☐ No

Has medication been considered for this youth? ☐ Yes ☐ No

Additional Information: ____

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

<u>Self-Care Skills</u>:

☐ Personal Hygiene ☐ Grooming ☐ Nutrition ☐ Dietary Planning ☐ Food Preparation ☐ Physical Health

☐ Self- Administration of Medication ☐ Maintain Personal Living Space ☐ Maintain Personal safety

<u>Social Skills</u>:

☐ Community Integration Activities ☐ Developing Natural Supports ☐ Age Appropriate Boundaries

☐ Anger Management/Conflict Resolution ☐ Mindful Coping Strategies ☐ Assertiveness/Self Esteem

☐ Interaction skills with Peers/Authority Figures ☐ Communication Skills

<u>Independent Living Skills</u>:

☐ Health Promotion and Training ☐ Community Resources ☐ Time Management

☐ Mindful Activities of Daily Living ☐ Individual Wellness Self-Management and Recovery

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Admission Criteria: All of the following criteria are necessary for admission.

☐ The youth ha a Public Behavioral Health System specialty mental health DSM-5 diagnosis and the youth's impairment(s) and functional behavior can reasonably be expected to be improved or maintained by using these services.

☐ The youth's emotional disturbance is the cause of serious dysfunction in multiple life domains:

☐ Home ☐Community ☐School

☐ The Impairment as a result of the youth's emotional disturbance results in:

☐ A clear, current threat to the youth's ability to be maintained in his/her customary setting, or

☐ An emerging/impending risk to the safety of the youth and others, or

☐ Other evidence of significant psychological or social impairments such as inappropriate social behavior causing serious problems with peer relationships and/or family members.

☐ The youth, due to the dysfunction, is at risk of requiring an out of home or residential placement or is returning from out of home or residential placement.

☐ The youth's condition requires an integrated program of rehabilitation services to return to age appropriate development and to progress accordingly towards independent functioning and independent living skills,

☐ The youth does not require a more intensive level of care and is deemed to be able to be safely maintained in the rehabilitation program and to benefit from the rehabilitation provided.

☐ A documented crisis response plan, including both family/guardian and the primary treating provider, is in progress or completed.

FUNCTIONAL CRITERIA: Within the past 3 months, the emotional disturbance resulted in: (Check all that apply and list objective evidence in this form, even if other evidence will be attached to this request.)

☐ A clear, current threat to the youth's ability to be maintained in their customary setting.

Evidence of clear, current threat to the youth's ability to be maintained in their customary setting:

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☐ Emerging risk to the safety of youth or others.

Evidence of emerging risk to the safety of youth or others:

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☐ Significant psychological or social impairment causing serious problem in peer relationships and/or family members.

Evidence of Significant psychological or social impairment causing serious problem in peer relationships and/or family members:

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What evidence exists to show the current intensity of outpatient treatment for the individual is insufficient to reduce the youth's symptoms and functional impairments resulting from mental illness?

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How will PRP serve to help this youth get to age appropriate development, more independent functioning, and independent living skills?

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Has a crisis plan been completed with family and/or guardian? ☐ Yes ☐ No

Has an individual treatment plan/individual rehabilitation plan been completed? ☐ Yes ☐ No

Is the child/adolescent appropriate for group? ☐ Yes ☐ No

Additional Clinical Rationale:

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____ ____________________

Clinical Treatment Provider Signature **Date**