**Referral for Psychiatric Rehabilitation Program (Child and Adolescent-PRP)**

**This form must be filled out in its entirety to determine medical necessity and authorization for services.**

Initial: □

Re-Referral: □

**Referral Source Information:**

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| --- | --- | --- | --- |
| **Name of person / agency making referral:** |  | **Date:** |  |
| **Address:** |  | | |
| **City/ State/ Zip Code** |  | | |
| **Mental Health Treatment Being Provided** | * Outpatient Mental Health Services * Inpatient Mental Health Services * Residential Treatment Center | | |

**Client Information:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client’s name:** |  | **Date of Birth:** |  | **Gender Identification:** |  | | **Race:** |  |
| **Address:** |  | **City, state, zip code** | |  | | | | |
| **Parent/Guardian’s name:** |  | **Relationship to child:** | | * Parent * Legal Guardian * Foster Care Provider | | * DSS * Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Phone number:** |  | **Parent/Guardian’s Email address:** | |  | | | | |
| **Client’s Medicaid #** |  | **Client’s Highest level of education** | |  | | | | |
| **Language(s) spoken in the home:** |  | **Is Interpretation Needed to Speak with Client?** | | * Yes * No * Unknown | | | | |
| **Is the participant eligible for fully funded Developmental Disabilities Administration services?\*** | * Yes * No * Unknown | **Access to transportation for onsite activities** | | * Yes * No * Unknown | | | | |
| **Does this client have a history of substance abuse?** | * Yes * No * Unknown | **Does client have a history of gambling?** | | * Yes * No * Unknown | | | | |
| **The youth has been engaged in active, documented outpatient treatment for:\*\*** | * Less than 1 month * Between 1-3 months * 6 months or more | **In the past three months, how many ER visits has the youth had for psychiatric care?\*** | | * No visits in the last 3 months * One visit in the last 3 months * 2 or more visits in the last 3 months | | | | |

**REASON FOR REFERRAL:** *(Indicate the areas you want the PRP to address.)*

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| --- | --- | --- | --- | --- |
| **Requested Services (Check all that apply)** | | | | |
| **Self-Care Skills**  Hygiene   * Nutrition * Physical Health * Personal safety | **Social Skills**   * Developing supports * Conflict resolution * Boundary awareness * Communication skills | **Independent Living Skills**   * Money management * Maintaining living env’t * Cooking/Shopping * Time management | **Community Resources Coordination**   * Identifying resources * Entitlement Application * Housing Coordination * Vocational/Job Skill | **Symptom Management**   * Psychoeducation * Coping skill development * Mental health education * Emotional Regulation |

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| **ICD-10 Primary Diagnosis Code:**  **A minor must have a behavioral diagnosis and be referred by a Licensed MH Professional to be eligible for PRP.** | | | | | |
| **Primary Behavioral Diagnosis code and description:** |  | | | | |
| **Secondary Behavioral Diagnosis code and description:** |  | | | | |
| **Diagnosis given by:** | * Referring Clinician | | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Social Elements Impacting Diagnoses:**  **(Required)** | * None * Unknown * Other: \_\_\_\_\_\_\_\_ | * Housing * Homelessness * Social Environmental | | * Educational * Primary support * Occupational | * Financial * Access to Healthcare * Legal System |

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| --- | --- | --- |
| **Functional Criteria (please provide explanation)**  **Within the past three months, the individual's emotional disturbance has resulted in:\*** | | |
| **A clear, current threat to the youth's ability to be maintained in their customary setting?\*\*** | **Yes** | **No** |
| *If yes, explain:* | | |
| **An emerging risk to the safety of the youth or others?\*\*** | **Yes** | **No** |
| *If yes, explain:* | | |
| **Significant psychological or social impairments causing serious problems with peer relationships and/or family members?\*\*** | **Yes** | **No** |
| *If yes, explain:* | | |
| **What evidence exists to show that the current intensity of outpatient treatment for this individual is insufficient to reduce the youth's symptoms and functional behavioral impairments resulting from mental illness?\*** | | |
| *Explain:* | | |
| **Has the youth made progress toward age appropriate development, more independent functioning and independent living skills?\*\*** | **Yes** | **No** |
| *Explain:* | | |
| **Has a crisis plan been completed with family and/or guardian?\*** | **Yes** | **No** |

**Mental Health Practitioner:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Print Name:** |  | **Date of referral** |  |
| **Signature, with credentials** |  | **Phone number:** |  |
| **Email address:** |  |
| ***Clinical supervisor, as applicable:*** |  |

Please include copies of the following:

* *Most recent psychiatric evaluation, as applicable*
* *Most recent biopsychosocial assessment, as applicable*
* *Records of Medication, as applicable*