**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:**

|  |  |  |  |
| --- | --- | --- | --- |
| **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.)*

|  |
| --- |
| **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
 |

|  |
| --- |
| **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
 |

|  |
| --- |
| **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*