**Referral for Psychiatric Rehabilitation Program (Adult-PRP)**

**Referral Source Information:**

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

**Consumer Information:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Client’s Name:** |  | **Date of Birth:** |  | **Age:** |  | |
| **Address:** |  | **Race:** |  | **Grade Last Completed:** |  | |
| **City, State, Zip, County:** |  | **Medicaid # (11 digits):** |  | **Sex:** | ☐ Male ☐ Female | |
| **Phone #:** |  | **Access to Transportation for On Site Activities:** | | | | ☐ Yes ☐ No |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Language(s) Spoken in the Home:** |  | **Is Interpretation Needed to Speak with Client?** | ☐ Yes ☐No | | | |

This form must be filled out in its entirety in order to allow for medical necessity and authorization for services. Please do not add diagnoses to the form.

**Behavioral Diagnoses**

|  |  |
| --- | --- |
| ☐ 295.90/F20.9 Schizophrenia | ☐ 296.53/F31.4 Bipolar I, Most Recent Depressed, Severe |
| ☐ 295.40/F20.81 Schizophreniform Disorder | ☐ 296.40/F31.0 Bipolar I, Most Recent Hypomanic |
| ☐ 295.70/F25.1 Schizoaffective Disorder, Depressive | ☐ 296.7/F31.9 Bipolar I Disorder, Unspecified |
| ☐ 298.9/F29 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder | ☐ 296.44/F31.2 Bipolar I, Most Recent Manic, with Psychosis |
| ☐ 295.70/F25.0 Schizoaffective Disorder, Bipolar Type | ☐ 296.54/F31.5 Bipolar I, Most Recent Depressed, w/o Psychosis |
| ☐ 298.8/F28 Other Specified Schizophrenia Spectrum and Other Psychotic Disorder | ☐ 296.40/F31.9 Bipolar I, Most Recent Hypomanic, Unspecified |
| ☐ 297.1/F22 Delusional Disorder | ☐ 296.89/F31.81 Bipolar II Disorder |
| ☐ 296.33/F33.2 MDD, Recurrent Episode, Severe | ☐ 301.83/F60.3 Borderline Personality Disorder |
| ☐ 296.34/F33.3 MDD, Recurrent, With Psychotic Features | ☐ 301.22/F21 Schizotypal Personality Disorder |
| ☐ 296.43/F31.13 Bipolar I, Most Recent Manic, Severe | ☐ 296.80/F31.9 Unspecified Bipolar Disorder |

**Primary Medical Diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Social Elements Impacting Diagnosis**

|  |  |  |  |
| --- | --- | --- | --- |
| ☐ None | ☐ Access to Health Care | ☐ Housing Problems | ☐ Social Environment |
| ☐ Educational | ☐ Legal System/Crime | ☐ Occupational | ☐ Homelessness |
| ☐ Financial | ☐ Primary Support | ☐ Other Psychosocial/Enviro. | ☐ Unknown |

**This individual has a serious mental illness which has required the intervention of the Public Mental Health System in the last two years:**

**Yes****☐ No****☐**

**Individual experiences at least three of the following:**

☐Inability to maintain independent employment

☐Social behavior that results in interventions by the mental health system

☐Inability to procure financial assistance due to cognitive disorganization

☐Severe inability to establish or maintain social supports

☐Need or assistance with basic living skills

Current Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the individual med compliant: ☐yes ☐no

**Please Answer the Following Questions**

1. **History of Presenting Problem**
2. **Please include information regarding level of functional impairment**
3. **Skills the participant requested to support his/her recovery**
4. **Skills to be addressed within the Individualized Recovery Plan**
5. **Participant’s identified support systems**

**Criminal History-** ☐yes ☐no

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

1. **Self-care skills-** ☐personal hygiene, ☐grooming, ☐nutrition, ☐dietary planning, ☐food preparation, ☐self administration of medication.
2. **Social Skills-** ☐community integration activities, ☐developing natural supports, ☐developing linkages with and supporting the individual’s participation in community activities.
3. **Independent living skills-** ☐skills necessary for housing stability, ☐community awareness, ☐mobility and transportation skills, ☐money management, ☐accessing available entitlements and resources, ☐supporting the individual to obtain and retain employment, ☐Health promotion and training, ☐individual wellness self management and recovery.

**Mental Health Practitioner:**

|  |  |
| --- | --- |
| Name: | Date: |
| Signature: | Date: |