**Referral for Psychiatric Rehabilitation Program (Child-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:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Child’s Name:** |  | **Date of Birth:** |  | **Age:** |  |
| **Address:** |  | **Race:** |  | **Grade:**  |  |
| **City, State, Zip, County:** |  | **Medicaid # (11 digits):** |  | **Sex:** | ☐ Male ☐ Female |
| **Phone #:** |  | **Access to Transportation for On Site Activities:** |  ☐ Yes ☐ No |
| **Adult Contact’s Name:** |  | **Relationship:** | ☐ Parent ☐ Guardian ☐ Foster Care Provider |
| **Address *(If different):*** |  | **Does Contact Person Have Legal Custody?** |  ☐ Yes ☐No |
| **City, State, Zip:** |  | **Phone Number:** |  |

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

**Please Answer the Following Questions**

1. **History of Presenting Problems**
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**

**DSM V DIAGNOSES*:*** (A minor must have a behavioral diagnosis and be referred by a Licensed MH Professional to be eligible for PRP.)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Primary Behavioral Diagnosis:** | Diagnosis Code: |  | Description: |  |
| **Secondary Behavioral Diagnosis:** | Diagnosis Code: |  | Description: |  |
| **Tertiary Behavioral Diagnosis:** | Diagnosis Code: |  | Description: |  |
| **Social Elements Impacting Diagnoses:***(Required)* | ☐ None ☐ Educational ☐ Financial ☐Access to Health Care ☐Legal System/Crime ☐ Primary Support ☐ Housing ☐ Occupational ☐ Social Environment ☐ Homelessness ☐ \*Other Psychosocial & Environmental ☐Unknown *\*Explain “Other Psychosocial & Environmental elements:* |
| **Source of Diagnosis:***(Name of Clinician or Psychiatrist and date of intake or evaluation required)* |  | **Functional Assessment***(If applicable)* | Measure Used: |  | Score: |  |

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

|  |  |  |  |
| --- | --- | --- | --- |
| ☐**Self Care Skills:** *(Check all that apply)* | ☐ personal hygiene/grooming☐ nutrition/dietary planning | ☐ dressing self☐ following routines (bed, school) | ☐ toileting☐ self administration of meds |
| ☐ **Semi-Independent Living Skills:***(Check all that apply)* | ☐ taking care of belongings☐ money management | ☐ maintaining living area☐ mobility skills | ☐ safety skills☐ accessing entitlements |
| ☐ **Interactive Skills with Others:**  *(Check all that apply)* | ☐ interactive skills with peers | ☐ interactive skills with family  | ☐ interactive skills with adults |
| ☐ **Leisure/Social Skills:** | ☐ community integration | ☐ participation in activities | ☐ developing natural supports |
| ☐ **Anger Management Skills:** | *Add’l info (if needed):* |
| ☐ **Education:** | *Add’l info (if needed):* |
| ☐ **Symptom Management:** | *Add’l info (if needed):* |
| ☐ **Community/Family Resources:** | *Add’l info (if needed):* |
| ☐ **Other**  | *Explain:* |

**Mental Health Practitioner:**

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