Adult Psychiatric Rehabilitation Program Referral Form

REFERRAL SOURCE INFORMATION	Date of Referral:	
Referring Agency Name:	Referring Agency Phone #:	
Referring Agency Address:		
Therapist Name:	Therapist Licensure:	
Email Address:	Phone #:	Fax #:

CONSUMER INFORMATION			
Name:	Medical Assistance #:		
Date of Birth:	Gender:	Race:	Hispanic? ☐ Y ☐ N
Address:	City/County:	Zip:	Phone #:
Legal Guardian Name:	Relationship:		Phone #:

ADMISSION CRITERIA – WHICH OF THE FOLLOWING DIAGNOSIS IS THE CONSUMER RECEIVING TREATMENT FOR? ENTER THE CORRECT CODE ON THE LINE			
_____ *Schizophrenia (F20.0, F20.1, F20.2, F20.3 F20.5)*	_____ *Schizophreniform Disorder (F20.81, F20.89)*	_____ *Delusional Disorder (F22.0)*	_____ *Schizoaffective Disorder (F25.0, F25.1, F25.8, F25.9)*
_____ *Other Specified Schizophrenia Spectrum and other Psychotic Disorder (F28)*	_____ *Unspecified Psychosis (F29)*	_____ *Bipolar I Disorder (F31.0, F31.2, F31.4, F31.5, F31.9, F31.13, F31.63, F31.64, F31.81)*	_____ Major Depressive Disorder, (F33.2, F33.3)
_____ Borderline Personality Disorder (F60.3)	_____ Bipolar II Disorder (F91.81)		Individuals w/*Cat A dx* must be enrolled in SSI or SSDI or have impaired functioning. Individuals w/Cat B dx must have impaired functioning.
Diagnosis Given By:		Date:	

Duration of current episode of treatment provided to this individual:	
Current frequency of treatment provided to this individual:	
Date of last therapy visit:	

Is the individual currently enrolled in SSI/SSDI?	☐ Y ☐ N
Is the individual eligible for full funding Developmental Disabilities Administration services?	☐ Y ☐ N
Is the primary reason for the individual's impairment due to an organic process or syndrome, intellectual disability, a neurodevelopmental disorder, or neurocognitive disorder?	☐ Y ☐ N
Has the individual been found not competent to stand trial or not criminally responsible and is receiving services recommended by Maryland Department of Health Education?	☐ Y ☐ N
Is the individual in a Maryland State psychiatric facility with a length of stay of more than 3 months who requires RRP upon discharge? *Select N if individual is eligible for Developmental Disability Services.*	☐ Y ☐ N

Adult Psychiatric Rehabilitation Program Referral Form

Will this person receive remuneration in any form from the PRP agency? ☐ Y ☐ N

Has this individual received PRP services from at least one other PRP provider within the past year? ☐ Y ☐ N

Please indicate which of the following program(s) the individual is also receiving services from?

☐	Mobile Treatment/Assertive Community Treatment (ACT)	☐	Inpatient Psychiatric Treatment	☐	Residential Crisis
☐	Mental Health Intensive Outpatient Program (IOP)	☐	SUD Intensive Outpatient Program (IOP) Level 2.1	☐	SUD Partial Hospitalization Program (IOP) Level 2.2
☐	Mental Health Partial Hospital Program	☐	Residential SUD Treatment Service Level 3.3	☐	Residential SUD Treatment Service Level 3.5
☐	Residential SUD Treatment Service Level 3.7				

FUNCTIONAL CRITERIA & DURATION OF IMPAIRMENTS: (*At least 3 of the following must be present on a continuing or intermittent basis over the past 2 years.)*

Check all that apply:

☐	Marked inability to establish or maintain competitive employment.	☐	Unable to perform self care.
☐	Marked inability to perform instrumental activities of daily living.	☐	Marked deficiencies in self direction shown by inability to plan, initiate, organize, and carry out goal directed activities.
☐	Marked inability to establish/maintain a personal support system.	☐	Marked inability to procure financial assistance to support community living .
☐	Deficiencies of concentration/persistance/pace leading to failure to complete tasks.	☐	Marked inability to procure financial assistance to support community living.
☐	Marked functional impairment has been present for less than 2 years.	☐	Marked functional impairment has been limited to l than 3 of the above listed areas.
☐	Has demonstrated marked impaired functioning primarily due to mental illness in at least three of the areas listed above at least 1-2years.	☐	Has demonstrated impaired role functioning primarily due to a mental illness for at least 3 years.

ALTERNATIVE SERVICE & TRANSITION CONSIDERATION:

Has consideration been given to using peer supports and other supports such as family?	Y	☐	N	☐
Can functional impairments be safely addressed at the PRP level of care?	Y	☐	N	☐
List attempts and outcomes of any efforts to serve this individual through less formal means such as peer supports or family.				
List specific ways in which PRP services are expected to help this individual.				

COLLABORATION AGREEMENT:

I, _____ (*Therapist Name and Title*), agree to participate in team treatment planning sessions/initial session within two weeks of receipt of the referral and quarterly sessions in person or by phone.

Therapist Signature: _____ Date: _____

Please attach Copies of the Current Biopsychosocial Evaluation, Court Orders and Treatment Plan

638 N. Gilmor St. Baltimore, MD 21217
410.462.ABOV (2268) *phone* 410.523.1434 *fax*
www.aiahealth.org