Minor Psychiatric Rehabilitation Program Referral Form

REFERRAL SOURCE INFORMATION	Date of Referral:
Referring Agency Name:	Referring Agency Phone #:
Referring Agency Address:	

Hello and thanks for your referral! If you are completing this referral but do not have the following licensure, you must have your Supervising Clinician sign the referral.

MD/DO, PhD/PsyD, LCSW-C, LCPC, LCMFT, APRN-PMH/CRNP-PMH, LCADC or LCPAT

Please print the information

Therapist Name:	Therapist Licensure:	
Email Address:	Phone #:	Fax #:

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

Primary Care Provider Name:	Phone #: Fax #:	Allergies:	School Name:
Current Therapist Name:	Current Therapist Phone:	Current Psychiatrist Name:	Current Psychiatrist Phone:

How often is the consumer in treatment per month?	
How long has the consumer been in outpatient therapy?	
How many Psychiatric ER Visits has the consumer had in the last 90 days? *Explain why if applicable.*	

Current Behavioral Dx (ICD-10):	**Dx Given By:**	**Date Dx Given:**	**Current Meds for Dx:**

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:

Supervising Clinician's Name: Signature:

Licensure Level:

Please attach Copies of the following:

1. **Current Psychosocial, Psychiatric or Psychological Evaluation**
2. **Current Court Orders**
3. **Current Therapist Treatment Plan**

For AIA Staff Only

Date Referral Received:

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

Minor Psychiatric Rehabilitation Program Referral Form

For Above It All to receive authorization for PRP services, it is imperative that you answer the below questions with detail and specific examples. *Thank you in advance!!*

EVIDENCE OF A CLEAR, CURRENT THREAT TO THE YOUTH'S ABILITY TO BE MAINTAINED IN THEIR CUSTOMARY SETTING *(List at least 3 things that the consumer struggles with and include detailed instances of how this behavior is displayed)*	
Behaviors	Examples

EVIDENCE OF AN EMERGING RISK TO SAFETY OF THE YOUTH OR OTHERS: *(List at least 3 ways that the consumer displays unsafe/harmful behaviors towards self or others with and include detailed instances of how this behavior is displayed)*	
Behaviors	Examples

EVIDENCE OF SIGNIFICANT PYSCHOLOGICAL OR SOCIAL IMPAIRMENTS CAUSING SERIOUS PROBLEMS WITH PEER RELATIONSHIPS AND/OR FAMILY. *(List at least 3 ways that the consumer displays behaviors that result in difficulty with maintaining relationships)*	
Behaviors	Examples

WHAT EVIDENCE EXISISTS 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?	
Behaviors	Examples

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