

P 240.459.8423

F 419.931.9255 www.cmntycare.com

Adolescent Psychiatric Rehabilitation Program Referral Form

Date:					
Referring Agency/A	ddress:				
Therapist Name:		Licensure Level:			
Phone:	Fax:	Email Add	lress:		
Consumer Name:		Gender:	DOB:		
Medical Assistance	#:	Race:			
Address:		Zip:	Phone:		
Legal Guardian:		Relations	ship (to minor):		
Legal Guardian Add	ress (if different f	rom above):			
School:		Address:	·		
Phone:		Grade:			
Primary Care Physician:		Address:	Address:		
Phone:		Fax:			
Is the individual elig	gible for full fundi	ng Developmental Dis	abilities Administration services?		
Yes No					
Have the family or p	eer supports bee	n successful in support	ting this youth? (Yes (No		
Is the primary reason	on for the individu	ıal's impairment due t	o an organic process or syndrome,		
intellectual disabili	ty, a neurodeveloj	omental disorder, or n	eurocognitive disorder? Yes No		
Does the youth mee	t the criteria for a	higher level of care th	an PRP? (Yes (No		
Will the youth's leve	el of cognitive imp	airment, current ment	tal status or developmental level impact		
their ability to bene	efit from PRP? Ye	s ONo			
Is youth currently in	n mental health ou	itpatient or inpatient t	reatment? Yes No		
Current Frequency	Of Treatment Pro	vided To This Individu	al:		
At least 1x/week	At least 1x/2 wee	eks At least 1x/mor	nth At least 1x/3 months		
At least 1x/6 mon	ths				
In the past three mo	onths, how many E	R visits has the youth	had for psychiatric care?		
No visits in the las	t three months	One visit in the last thi	ree months CTwo or more visits in the		
last three months					

Date: _____



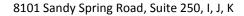
sessions in person or by phone.

Therapist Signature: _____

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www.cmntycare.com Is the youth transitioning from an inpatient, day hospital or residential treatment setting to a community setting? Yes No Does the youth have a Targeted Case Management referral or authorization? Yes No Has medication been considered for this youth? Not considered Considered and Ruled Out (Initiated and Withdrawn (Ongoing Other **FUNCTIONAL CRITERIA** Within the past 3 months, the emotional disturbance has resulted in. Check all that apply and list evidence: Evidence of clear, current threat to the youth's ability to be maintained in their customary Evidence of emerging risk to the safety of the youth or others. Evidence of significant psychological or social impairments causing serious problems with peer relationships and/or family members. 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? • How will PRP serve to help this youth get to age-appropriate development, more independent living skills? Has a crisis plan been completed with family and/or guardian? o Has an individual treatment plan/individual rehabilitation plan been completed? _____ Behavioral Diagnosis (*Please use the current DSM V, ICD-10 diagnoses*) Date: ____ Date: _____ Diagnosis given by: _____ Date: ____ 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





Laurel, MD 20707

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For Community Care, LLC Only	7
Date Referral Received:	
Received By:	