8101 Sandy Spring Road, Suite 250, I, J, K

Laurel, MD 20707

P 240.459.8423

F 419.931.9255
www.cmntycare.com

Adolescent Psychiatric Rehabilitation Program Referral Form

Date: ______________________________

Referring Agency/Address: ______________________________

Therapist Name: ____________________ **Licensure Level:** ______________________________

Phone: __________________ **Fax:** ________________ **Email Address:** ______________________________

Consumer Name: __________________________ **Gender:** ____________ **DOB:** ____________________

Medical Assistance #: ____________________ **Race:** ______________________________

Address: ______________________________ **Zip:** ____________________ **Phone:** ____________

Legal Guardian: ______________________________ **Relationship (to minor):** ________________

Legal Guardian Address (if different from above): ______________________________

School: ______________________________ **Address:** ______________________________

Phone: ______________________________ **Grade:** ______________________________

Primary Care Physician: __________________ **Address:** ______________________________

Phone: ____________________________ **Fax:** ______________________________

Is the individual eligible for full funding Developmental Disabilities Administration services?

◯Yes ◯No

Have the family or peer supports been successful in supporting this youth? ◯Yes ◯No

Is the primary reason for the individual's impairment due to an organic process or syndrome, intellectual disability, a neurodevelopmental disorder, or neurocognitive disorder? ◯Yes ◯No

Does the youth meet the criteria for a higher level of care than PRP? ◯Yes ◯No

Will the youth's level of cognitive impairment, current mental status or developmental level impact their ability to benefit from PRP? ◯Yes ◯No

Is youth currently in mental health outpatient or inpatient treatment? ◯Yes ◯No

Current Frequency Of Treatment Provided To This Individual:

◯At least 1x/week ◯ At least 1x/2 weeks ◯At least 1x/month ◯At least 1x/3 months

◯At least 1x/6 months

In the past three months, how many ER visits has the youth had for psychiatric care?

◯No visits in the last three months ◯One visit in the last three months ◯Two or more visits in the last three months

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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.

List evidence for each of the following:

- **Evidence of clear, current threat to the youth's ability to be maintained in their customary setting.**

  ____
  ____
  ____
  ____
  ____

- **Evidence of emerging risk to the safety of the youth or others.**

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  ____
  ____
  ____
  ____

- **Evidence of significant psychological or social impairments causing serious problems with peer relationships and/or family members.**

  ____
  ____
  ____
  ____
  ____

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- **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?** ____________________
- **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 sessions in person or by phone.**

Therapist Signature: ______________________ **Date:** ____________________

For Community Care, LLC Only
Date Referral Received: ______________________
Received By: ______________________________