

Channel Marker

MENTAL HEALTH SUPPORT SERVICES

8626 Brooks Drive, Unit 304, Easton, MD 21601

Phone: 410.822.4619 FAX: 410.822.0984

www.channelmarker.org

REFERRAL FORM

SERVICES BEING REFERRED TO:

- Adult PRP (Caroline County, Dorchester County, Talbot County)
- Youth PRP (Caroline County, Dorchester County, Talbot County)
- Transitional Age Youth PRP (Talbot County, Caroline County, Dorchester County)
- Supported Employment (Talbot County)

Adult Residential Referrals - Must contact Mid Shore Mental Health Systems, 410.770.4801, for referral form. All Residential Referrals must go through them.

PLEASE SEND REFERRAL FORM AND ADDITIONAL INFORMATION TO:

- | | | |
|--|---|---|
| <input type="checkbox"/> Channel Marker, Inc.
Caroline County Program
508 Kerr Avenue
Denton MD 21629
410.479.2318 – phone
410.820.0124 - fax | <input type="checkbox"/> Channel Marker, Inc.
Dorchester County Program
420 Dorchester Avenue
Cambridge MD 21613
410.228.8330 – phone
410.221.6459 - fax | <input type="checkbox"/> Channel Marker, Inc.
Talbot County Program
222 Port St.
Easton MD 21601
410.822.4611 – phone
410.822.6186 - fax |
|--|---|---|

To Be Completed by Referral Source:

Channel Marker, Inc. requests clinical information from your agency in order to obtain Value Options authorization to process each referral.

Please include with the completed referral the following, as available:

- | | |
|---|--|
| <input type="checkbox"/> Current Mental Health Treatment Plan (ITP)
<input type="checkbox"/> Current Social History/Intake/Evaluation
<input type="checkbox"/> Current Psychological and/or Psychiatric Evaluation
<input type="checkbox"/> Relevant <u>past</u> social, psychological, and/or psychiatric evaluations
<input type="checkbox"/> Discharge Summaries/Treatment plans from last placement/hospitalization | <input type="checkbox"/> Medical records/evaluations and developmental history
<input type="checkbox"/> Education/Vocational Evaluations
<input type="checkbox"/> Neurological Assessment (if indicated)
<input type="checkbox"/> Documentation of physical examination within the past 12 months |
|---|--|

Signature of Referring Psychiatrist or Therapist: _____

Print Name: _____ **Title:** _____

Referring Agency: _____ **Phone Number:** _____

AUTHORIZATION AND RELEASE INFORMATION

I, _____, understand that application for rehabilitation services
Client/Parent or Guardian Printed name
is being made on behalf of me and I agree to this referral for services. I do hereby give permission to Channel Marker, Inc. to provide psychiatric rehabilitation services, including assessment and rehabilitation planning. I authorize _____ to release/exchange information to Channel Marker, Inc. for
Referring Agency
the purpose of facilitating the referral process. I understand the information exchanged may include diagnosis, evaluations, and progress reports.

_____ In addition, I authorize Channel Marker, Inc. to release/exchange information to Treatment Provider
Client Initials
(psychiatrist and therapist) and Emergency Contact for the purpose of facilitating the referral process.

I understand I may revoke this consent by written request to Channel Marker, Inc.

Signed: _____ **Date:** _____
Client/Parent or Guardian Signature

Witness/Staff: _____ **Date:** _____

I. DEMOGRAPHIC INFORMATION

Name: _____ Age: _____ SSN: _____

Address: _____ Phone: _____

Legal Guardian/Relationship to Client (if applicable): _____

Primary Caretaker (if applicable): _____

Date of Birth: _____ Gender: Male Female Transgender

Race: _____ Sexual Orientation: _____

Marital Status: Single Married Separated Divorced

Veteran? Yes No What war? _____ Dates of service: _____

Would the consumer like to be contacted by the Office of MD's Commitment to Veterans for the purpose of
Veteran Benefits? Yes No Unknown Already in contact

Is this individual a hurricane victim? Yes No Living situation: _____

Is this individual pregnant? Yes No Number of arrests in past 30 days: _____

Has this individual participated in a self-help group in the past 30 days? Yes No

How well does the consumer speak English? Very Well Well Not Well Not at All Unknown

Does the consumer speak a language other than English? Yes (specify): _____ No Unknown

Emergency Contacts: (Two contacts must be completed for ALL Youth Referrals, one contact for Adult Referrals)

1. Emergency Contact Name: _____ Relationship: _____

Address: _____ Phone: _____

2. Emergency Contact Name: _____ Relationship: _____

Address: _____ Phone: _____

Medical Physician: _____ Phone: _____

Address: _____

Psychiatric Physician: _____ Phone: _____

Address: _____

Primary Therapist/Credentials: _____ Phone: _____

Address: _____

II. FINANCIAL INFORMATION

Medicaid Number: _____ Effective Date: _____

Other Insurance Type: _____

Current Entitlements/Amount:

SSI Amount: _____ SSDI Amount: _____ Other: _____ Amount:

Employed: Employer: _____

Job Title: _____ Wages: _____ / _____

DISABILITY STATUS

Is the consumer deaf or do they have serious difficulty hearing? Yes No Unknown

Is the consumer blind or do they have serious difficulty seeing, even when wearing glasses?

Yes No Unknown

Because of a physical, mental, or emotional condition, does the consumer have serious difficulty concentrating, remembering, or making decisions? Yes No Unknown

Does the consumer have serious difficulty walking or climbing stairs? Yes No Unknown

Does the consumer have difficulty dressing or bathing? Yes No Unknown

Because of physical, mental, or emotional condition, does the consumer have difficulty doing errands alone such as visiting a doctor's office or shopping? Yes No Unknown

III. EDUCATION/EMPLOYMENT

School Name/Highest Grade Completed: _____

Diploma: Yes No Certificate of Attendance: Yes No

If currently enrolled in school, Current School Status/Grade: _____

Additional Education/Training: _____

Work History (positions, dates, volunteer or paid):

IV. CLINICAL CRITERIA

Priority Population – ADULTS ONLY (see below for Youth)

- 295.90/F20.9 Schizophrenia
- 295.40/F20.81 Schizophreniform Disorder
- 295.70/F25.0 Schizoaffective Disorder, Bipolar Type
- 295.70/F25.1 Schizoaffective Disorder, Depressive Type
- 298.8/F28 Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
- 298.9/F29 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
- 297.1/F22 Delusional Disorder
- 296.33/F33.2 Major Depressive Disorder, Recurrent Episode, Severe
- 296.34/F33.3 Major Depressive Disorder, Recurrent Episode, With Psychotic Features
- 296.43/F31.13 Bipolar I Disorder, Current or Most Recent Episode Manic, Severe
- 296.44/F31.2 Bipolar I Disorder, Current or Most Recent Episode Manic, With Psychotic Features
- 296.53/F31.4 Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe
- 296.54/F31.5 Bipolar I Disorder, Most Recent Episode Depressed, With Psychotic Features
- 296.40/F31.0 Bipolar I Disorder, Current or Most Recent Episode Hypomanic
- 296.40/F31.9 Bipolar I Disorder, Current or Most Recent Episode Hypomanic, Unspecified
- 296.7/F31.9 Bipolar I Disorder, Current or Most Recent Episode Unspecified
- 296.80/F31.9 Unspecified Bipolar and Related Disorder
- 296.89/F31.81 Bipolar II Disorder
- 301.22/F21 Schizotypal Personality Disorder
- 301.83/F60.3 Borderline Personality Disorder
- Other Diagnoses in addition to the Priority Population Diagnosis: (Please list)

YOUTH DSM-V DIAGNOSIS (see above for Adults)

CODE	DIAGNOSIS

MEDICATIONS (name, dosage, monitoring needs):

Is the client taking medications as prescribed? Yes No Date of last therapy session: _____

V. REASON FOR REFERRAL

What are the goals for PRP/Why is the client being referred?

List client's strengths and areas of interest:

List client's areas of needed improvement:

VI. TREATMENT AND SERVICE HISTORY

History of psychiatric hospitalizations (include dates, hospital, reason, length of stay)

Number of Emergency Room or other crisis episodes in the last 12 months: _____

Number of Inpatient Admissions in the last 12 months: _____ Lifetime Hospitalizations: _____

Reason for ER visit or Inpatient Admission (if known): _____

Describe behaviors and/or symptoms which indicate decompensation: _____

Describe history of criminal records: N/A

Currently on Probation/Parole/Conditions of Release or involved with DJS: Yes No

If yes, explain charges/convictions:

Is there a Court Order for this client to attend PRP: Yes No

If yes, explain and attach a copy of the order:

Describe Substance Abuse History: N/A

Describe Medical Conditions that could impact participation/Significant medical history:

VII. RISK BEHAVIOR CHECKLIST

If behaviors have occurred within the last 30 days, provide additional information in the Comment section including date of last occurrence.

Behavior/Problem	Current (30 days)	Within Last 12 Months	Over 1 year
Suicidal/Homicidal Threat/Attempt Comment:			
Self Injurious Behaviors Comment:			
Possession/Use of Weapons Comment:			
Fire Setting Comment:			
Chronic Anger/Aggression (physical, verbal, destruction of property etc.) Comment:			
Trauma Related Symptoms Comment:			
Sexually Inappropriate Behaviors (perpetrator, promiscuous) Comment:			
Social Interpersonal Conflicts Comment:			
Family Problems/Peer Conflicts Comment:			
Coping With Daily Roles & Activities Comment:			
Learning Difficulties/School or Vocational Problems Comment:			
Runaway Behavior Comment:			
Other Behaviors Please Describe:			