8101 Sandy Spring Road,
Suite 250, I, J & K
Laurel, MD. 20707

Office: 240.459.8423
Fax: 419.931.9255
info@cmntycare.com

PSYCHIATRIC REHABILITATION SERVICES
PROGRAM REFERRAL FORM

REFERRAL SOURCE INFORMATION

Date of Referral: ____________________ School Location (If Applicable): ______________________

Referring Agency/Address: ____

Referring Worker (title and credentials): _________________________ Phone______________________

Email Address: ____ Fax Number: _________________

CLIENT INFORMATION

Consumer Name: _____________________________ Gender: ____________ Marital Status: ______________

SSN: ________________________ DOB: _______________ AGE: ______________ RACE: ___________

Medical Assistance #: _____________________________ Legal Guardian: ______________________________

Full Address: ____

Phone: _____________________________ Alternate Phone: _____________________________

Primary Care Physician: _______________________ Phone Number: ______________________________

Employer/School: ____ Grade: _________________________

Address: ____ Phone:_______________________

Rehabilitation Services Needed:

- ❑ Activities of Daily Living
- ❑ Anger/Temper/Conflict Resolution
- ❑ Assertiveness/Self-esteem
- ❑ Community Activity
- ❑ Family/Natural Supports
- ❑ Finances
- ❑ Home/Housing
- ❑ Self Care Skills
- ❑ Safety to Self/Others
- ❑ School Performance
- ❑ Sexual Issues
- ❑ Social Skills/Peer Interaction
- ❑ Substance Abuse Issues
- ❑ Coping Skills
- ❑ Trauma
- ❑ Medication Compliance Skills
- ❑ Vocational Skills
- ❑ Leisure Skills
- ❑ Work/Job Performance
- ❑ **Legal Issues (# of arrests? ____)**
- ❑ Money Management
- ❑ Dietary/Food Preparation
- ❑ Crisis Management Skills
- ❑ Physical Health

History of Problems: i.e. (school suspensions, hospitalizations, runaways within the last 30 days, physical assault)

____

____

Current Treatment: Please list the locations, dates, responsible parties and phone numbers of inpatient or outpatient settings in which the consumer currently participates.

1. ____

2. ____

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Diagnosis: please indicate current DSM V diagnoses.

ICD 10 Code: ____ DSM V Code: _________

ICD 10 Code: ____ DSM V Code: _________

ICD 10 Code: ____ DSM V Code: _________

ICD 10 Code: ____ DSM V Code: _________

Diagnosis given by: ___________________________________ Date: ______________________

Medications

Type	**Dosage/Frequency**	**Prescribed By:**

(Please include additional MEDS in your summary)

Additional Comments/Concerns: ____

____

____

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.*

Date: _________________________

Please Attach Copies Of The Following:

1. Current Psychosocial, Psychiatric or Psychological Evaluation

2. Court Order (If child is committed to DSS or DJS)

3. Current Therapist Treatment Plan

FOR COMMUNITY CARE STAFF USE ONLY

Date of Referral Received:_____________________ **Received By:** ____________________

Date Referral Source Contacted? _______________ **Date Client Contacted:** ___________

Value Options Authorization Date: ______________

Rehabilitation Specialist Assigned: ______________ **Date of Assignment:** _____________