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◯Not considered ◯Considered and Ruled Out ◯Initiated and Withdrawn ◯Ongoing ◯Other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.

Check all that apply and list evidence:

- **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. _____**
- **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? _____**
- **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: _____

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