**Referral Form (Child)**

Please complete this form in its entirety.

­­­­­­­­­­­­­ **Referral Source Information**

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| Referring Agency Name: |
| Individual Name/ Credentials: |
| Address: |
| Phone: |
| Location: |
| Email Address: |
| Date of Referral:  |
| Clinician Signature: |

**Client Information**

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| Client Name: |
| Parent/ Guardian Name: |
| Parent/Guardian Address: |
| Parent/Guardian Phone Number: |
| Parent/Guardian Email Address: |
| Client Date of Birth: |
| Client Age: |
| Client Gender: |
| Client Ethnicity: |
| Client Medicaid #: |
| Client MCO: |
| Client Social Security: |
| Client Home Address: | Is the client homeless?**Yes or No** |
| Client Home Phone: |
| Client Cell Phone: |
| Other Phone: |
| Client Email Address: |
| Is there current or previous substance abuse? | If yes, currently in treatment? **Yes or No** |

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| Is client currently on Psychotropic Medications (circle one): **Yes or No** |
| If yes, please list all medications: |
| Has medication been considered, not considered, or ruled out for client? (chose one) |

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| **Primary ICD -10 Diagnosis Code:**  |

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| Has client recently been discharged from an outpatient Mental Health Facility/Hospital? | If yes, have they provided a copy of the aftercare plan? |
| Has the client been arrested in the past six months? | If yes, how many times? |
| Currently enrolled in education programs? | Highest grade completed:School name: |
| Currently employed? |

**Functional Impairment(s):**

*Within the past three months, the individual’s emotional disturbance has resulted in:*

A clear, current threat to the youth’s ability to be maintained in their customary setting? **Yes or No**

Evidence of a current threat to the youth’s ability to be maintained in their customary setting:

An emerging risk to the safety of the youth or others? **Yes or No**

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| Evidence of an emerging risk to the safety of the youth or others: |

Significant psychological or social impairments causing serious problems with peer relationships and/or family members? **Yes or No**

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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? |

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| How will PRP serve to help this youth get to age-appropriate development, more independent functioning, and independent living skills? |

Has a crisis plan been completed with a family and/or guardian? **Yes or No**

Has an individual treatment plan/individual rehabilitation plan been complet6ed? **Yes or No**

Functional impairments can be safely address at the PRP level of care. **Yes or No**

**Confirmation & Attestation**

[ ] I attest all the information provided is accurate and reflected in the participant’s medical record.