**Referral Form (Adult)**

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

|  |
| --- |
| 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:  |

|  |  |
| --- | --- |
| 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? |
| Is the client a Veteran? |
| Currently enrolled in education programs? | Highest grade completed?:School name: |
| Currently employed? |

**Functional Impairment(s):**

(Check all that apply and list objective evidence in this form, even if other evidence will be attached to this request.)

[ ] Marked inability to establish or maintain competitive employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Marked inability to perform instrumental activities of daily living (eg: shopping, meal preparation, laundry, basic housekeeping, medication management, transportation, and money management): \_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Marked inability to establish/ maintain a personal support system: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Deficiencies of concentration/persistence/pace leading to failure to complete tasks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Unable to perform self-care (hygiene, grooming, nutrition, medical care, safety): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Marked deficiencies in self-direction, shown by inability to plan, initial, organize, and carry out goal directed activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Marked inability to procure financial assistance to support community living:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| List specific ways in which PRP service are expected to help this individual (List attempts and outcomes of any efforts to serve this individual through less formal means such as peer supports or family): |

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

Confirmation & Attestation

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