FOUNDATIONS ACHC ACCREDITED

Psychiatric Rehabilitation Program

# INITIAL REFERRAL FORM

| Today's Date: | Type of Referral: ☐ On Site ☐ Off Site Sex: ☐ Both |
|---|---|

## REFERRAL SOURCE INFORMATION

| Name: | Title: | Email: |
|---|---|---|
| Agency: | Phone: | Fax: |

## PARTICIPANT INFORMATION

| Last Name: | First Name: | Middle: |
|---|---|---|

| Date of Birth: | Age: | Sex: ☐ F ☐ M | Social Security No: | Home Phone: | Cell Phone: |
|---|---|---|---|---|---|

| Address: | | |
|---|---|---|
| Emergency Contact: | Address: | Phone: |
| Does participant have a guardian of person or property? ☐ Yes ☐ No If so, who? | | Phone: |

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Never Married ☐ Widowed Employed? ☐ Yes ☐ No If So: ☐ Full-Time ☐ Part-Time

Describe the Participant's Support System:

## INSURANCE/FINANCIAL INFORMATION

| Medical Assistance No.: | If the Participant does not have Medical Assistance, what was the date of application? | |
|---|---|---|
| Medicare No.: | Other Insurance: ☐ Yes ☐ No | If yes, name of carrier: |

## REASON FOR REFERRAL

*Check all that apply*:*

☐ **Emotional/Mental Illness** - Social behavior resulting in interventions by the mental health system
☐ **Employment/ Occupational** - Inability to maintain independent employment
☐ **Financial Difficulty** - Inability to procure financial assistance due to cognitive issues
☐ **Behavior Conduct/Crisis Intervention** - dangerous behavior issues
☐ **Social Environment/Interpersonal Skill issues** - Severe inability to establish or maintain social supports
☐ **Educational/School Problems**
☐ **Housing Problems/Homelessness/At Risk of Homelessness**
☐ **Anger Management/Conflict Resolution**
☐ **Activities of Daily Living** - Need or assistance with basic living skills
☐ **Access to Health Care**
☐ **Other Psychosocial/Environment** - including adaptive resources

☐ **Legal System/Crime/Incarceration Issues**
☐ **Medication Compliance/Monitoring**
☐ **Physical/Emotional Abuse**
☐ **Sexual Abuse**
☐ **Relationship Issue/Conflict**
☐ **Primary/Family Support**
☐ **Substance Abuse** (participant or family)
☐ **Suicidal/Homicidal Risk**
☐ **CPS/APS/DSS Involved**
☐ **Independent-living Skill Training**
☐ **Personal Hygiene/Grooming**

**At least three are required to meet the medical necessity criteria.*

## PRP SERVICES REQUESTED

*Check all that apply:*

| | |
|---|---|
| **Self-Care Skills** | ☐ Personal Hygiene ☐ Grooming ☐ Nutrition ☐ Dietary Planning ☐ Food Preparation ☐ Self-Administration of Medication. |
| **Social Skills** | ☐ Community Integration Activities ☐ Developing Natural Supports ☐ Supporting the Individual's Participation in Community Activities ☐ Social Relationships & Leisure Activities ☐ Recovery Challenges |
| **Independent Living Skills** | ☐ Skills necessary for Housing Stability ☐ Community Awareness ☐ Mobility and Transportation Skills ☐ Money Management ☐ Accessing available Entitlements and Resources ☐ Supporting the Individual to obtain and retain Employment ☐ Health Promotion and Training Individual Wellness ☐ Self -Management and Recovery ☐ Education and Vocational Training |

## PRESENTING COMPLAINTS, SYMPTOMS AND BEHAVIORS

*Check all that apply:*

| | | | | | |
|---|---|---|---|---|---|
| ☐ Anxiety/Panic | ☐ Depression | ☐ Suicidal/Homicidal Ideation | ☐ Stealing | ☐ Hyperactive | ☐ Property Destruction |
| ☐ Irritable | ☐ Isolative | ☐ Manipulative/Lying | ☐ Manic Mood | ☐ Obsession/Compulsion | ☐ Oppositional Defiant |
| ☐ Physical Aggression | ☐ Impulsive | ☐ Hopelessness/ Helplessness | ☐ Self-Care Deficit | ☐ Self-Injurious Behavior | ☐ Harm to Others |
| ☐ Separation Problems | ☐ Wandering | ☐ Sexually Inappropriate | ☐ Trauma-Related | ☐ Verbal Aggression | ☐ Other Psychosocial Issues |

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## CLINICAL INFORMATION

Authorizations Require a DSM 5 Diagnosis. Please check all that apply:

| | |
|---|---|
| ☐ F20.9 Schizophrenia | ☐ F31.2 Bipolar I, Most Recent Manic, with Psychosis |
| ☐ F20.81 Schizophreniform Disorder | ☐ F31.4 Bipolar I, Most Recent Depressed, Severe |
| ☐ F25.0 Schizoaffective Disorder, Bipolar Type | ☐ F31.5 Bipolar I, Most Recent Depressed, with Psychosis |
| ☐ F25.1 Schizoaffective Disorder, Depressive | ☐ F31.0 Bipolar I, Most Recent Hypomanic |
| ☐ F28 Other Specified Schizophrenia Spectrum/Other Psychotic Disorder | ☐ F31.9 Bipolar I, Most Recent Hypomanic, Unspecified |
| ☐ F29 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder | ☐ F31.9 Bipolar I Disorder, Unspecified |
| ☐ F22 Delusional Disorder | ☐ F31.9 Unspecified Bipolar Disorder |
| ☐ F33.2 Major Depressive DO, Recurrent Episode, Severe | ☐ F31.81 Bipolar II Disorder |
| ☐ F33.3 Major Depressive DO, Recurrent, With Psychotic Features | ☐ F21 Schizotypal Personality Disorder |
| ☐ F31.13 Bipolar I, Most Recent Manic, Severe | ☐ F60.3 Borderline Personality Disorder |

Please list any allergies:

Please list current medications and dosage:

Medication compliance history:

| Total number of past hospitalizations: | Date and Location of most recent hospitalization: | Reason for admission: |
|---|---|---|
| | | |

## SUBSTANCE ABUSE INFORMATION

| History of Substance Abuse? ☐ Yes ☐ No | Has the Participant received inpatient or outpatient substance abuse treatment? ☐ Yes ☐ No | If yes, date and location: |
|---|---|---|
| | | |

Please describe substance abuse history:

## MEDICAL DIAGNOSES

Please list any current medical diagnoses:

## TREATMENT PROVIDERS

| | | | | |
|---|---|---|---|---|
| **Primary Care Physician (PCP):** Organization: | Address: | Phone No.: | Fax No.: | Email: |
| **Psychiatrist:** Organization: | Address: | Phone No.: | Fax No.: | Email: |
| **Mental Health Therapist:** Organization: | Address: | Phone No.: | Fax No.: | Email: |
| **Other:** Organization: | Address: | Phone No.: | Fax No.: | Email: |

## SIGNATURE OF REFERRAL SOURCE

Referral Source Signature and Credentials

Date