FOUNDATIONS ACHC ACCREDITED

Medical Adult Day Center (MADC) & Psychiatric Rehabilitation Program (PRP)

INITIAL REFERRAL FORM

Today's Date:	Type of Referral: ☐ PRP ☐ MADC ☐ 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.*

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

Fax Referrals to (443) 400-8392 or Email them to: referrals@foundationsgroup.net

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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

Foundations Medical Adult Day Services
1025 W Nursery Road, Suite 118
Linthicum, MD 21090
Phone: (443) 422-6939
Fax: (443) 400-8392