Psychiatric Rehabilitation Program & Medical Adult Day Care Referral

Foundations Group

Fax: 410.690.7479

Foundations Group

○ PRP Program ○ Medical Adult Day Care ◉ Both Programs

To efficiently process referrals, please fill out this form in its entirety, sign, and date.

Date:_____ Consumer Name: _____

Last 4 of SS# _____ DOB:_____ Gender: _____ Race: _____

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____Physical Description:_____

Is Consumer a Veteran_No__Does Consumer have DDA funding? Yes

Emergency Contact: _____Contact's Phone: _____

Current consumer status (please indicate to assist in the prioritization of referrals):

- ☐ Inpatient-projected release date: _____
- ☐ Partial Hospitalization- projected release date: _____
- ☐ Crisis Bed/Other crisis facility-projected release date: _____
- ☐ Outpatient
- ☐ Date of most recent inpatient discharge: _____
- ☐ Other: _____

DSM 5 Behavioral Diagnoses: **(choose only one)**

Priority Pop. DSM-5 / ICD-10 Behavioral Diagnosis: (consumer must have one of these diagnoses as primary to qualify for services)

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

Additional Behavioral Health Diagnosis:

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Primary Medical Diagnosis: _____

Social Elements Impacting Diagnosis: (check all that apply)

- ☐ None
- ☐ Problems with access to health care services
- ☐ Housing problems (Not Homelessness)
- ☐ Problems related to social environment
- ☐ Educational problems
- ☐ Problems related to interaction w/legal system/crime
- ☐ Occupational problems
- ☐ Homelessness
- ☐ Financial problems
- ☐ Problems with primary support group
- ☐ Other psychosocial and environmental problems
- ☐ Unknown

Functional Assessment: _____

Definition of Problem Areas (Current Symptoms):

Reason(s) for seeking treatment (check all that apply):

- ☐ Linkage to community resources/community integration
- ☐ Facilitating transition from more intensive services
- ☐ Prevention/reduction of hospitalization or rehospitalization
- ☐ Coordination of current community services

Risk for Aggressive Behaviors, Suicide, or Homicide: (explain):

Entitlement Information:

SSI monthly: $_____ Date Active: _____

SSDI monthly: $_____ Date Active: _____

Medicaid #:_____ Date Applied / Active _____

Other Income/Insurance: _____

Upon the clinician's signature below, the consumer being referred is appropriate for psychiatric rehabilitation program services provided Foundations Group, Inc. This referral must be signed by a physician, nurse practitioner, or independently licensed clinician (LCSW-C or LCPC.)

I,_____, refer_____

(Clinician's Signature) (Print Consumer's Name)

_____ _____

(Print Clinician's Name and Credentials) (Clinician's Phone Number)

Referring Agency: _____