

Psychiatric Rehabilitation Program & Medical Adult Day Care Referral

Foundations Group

Fax: 410.690.7479



PRP Program

Medical Adult Day Services

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 Yes No Does Consumer have DDA funding? Yes No

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: _____

CrisisBed/Othercrisisfacility-projectedreleasedate: _____

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 Features
- F31.4 Bipolar I Disorder, Current or most Recent Episode Depressed, Severe
- F31.5 Bipolar I Disorder, Current or most Recent Episode Depressed, Severe with Psychotic Features
- F31.0 Bipolar I Disorder, Current or most Recent Episode Hypomanic
- F31.9 Bipolar I Disorder, Current or most Recent Episode Hypomanic, Unspecified
- F31.9 Bipolar I Disorder, Current or Most Recent Episode 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:

Primary Medical Diagnosis: _____

Social Elements Impacting Diagnosis: (check all that apply)

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

Functional Assessment: _____

Definition of Problem Areas (Current Symptoms):

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

Linkage to community resources/community integration	Prevention/reduction of hospitalization or rehospitalization
Facilitating transition from more intensive services	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: _____