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: ____________________________
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 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 Unspecified Bipolar and Related Disorder
F31.81 Bipolar II Disorder
F21 Schizotypal Personality Disorder
F60.3 Borderline Personality Disorder

Additional Behavioral Health Diagnosis:

Please continue page 2

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: ____