Psychiatric Rehabilitation Program & Medical Adult Day Services Referral Form

Phone: 410.789.7772
Fax: 443.400.8392

Foundations Group

☐ 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_____

Print Clinician's Name and Credentials — Print Consumer's Name

_____ _____

Clinician's Signature and Date — Clinician's NPI Number:

Referring Agency: _____ Clinician's Phone Number: _____

Email Address: _____