



August Rose Health Center
Together. We Rise

**Child and Adolescent
PRP Referral Form**

Referral Source					
Name:		Affiliated Clinic:			
Address:					
Phone number:		Fax:		Email address:	

Client Information							
Name:		DOB:		Gender:		Race:	
Address:							
Phone number:		Additional:					
Insurance #:		Marital Status:		Native Language:			
Legal Guardian:							
How long has this client been in services with you?				How often do you meet with client?	<input type="radio"/> Weekly <input type="radio"/> Biweekly <input type="radio"/> Monthly Other		
Please provide dates of last 4 provider sessions with client:	Date:		Date:		Date:		Date:
Substance Abuse History	Yes Or No <i>If Yes, Indicate Substance(s) of choice:</i>						
Suicidal	Yes Or No <i>If Yes, Indicate history:</i>						
Homicidal	Yes Or No <i>If Yes, Indicate history:</i>						

Qualifying Diagnosis	
ICD-10 Primary Diagnosis Code:*	
Primary:	
Secondary:	
Other:	



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1. Is the participant eligible for fully funded Developmental Disabilities Administration services? **Yes Or No**
2. Have family or peer support been successful in supporting this youth? **Yes Or No**
3. Is the primary reason for the participant's impairment due to an organic process or syndrome, intellectual disability, a neurodevelopmental disorder, or neurocognitive disorder? **Yes Or No**
4. Is the youth transitioning from an inpatient, day hospital or residential treatment setting to a community setting? **Yes Or No**
5. Has medication been considered for this youth? **Yes Or No**

Comments:

Requested Services (Check all that apply)

Self-Care Skills	Social Skills	Independent Living Skills	Community Resources Coordination	Symptom Management
<input type="checkbox"/> Nutrition <input type="checkbox"/> Physical Health <input type="checkbox"/> Personal safety <input type="checkbox"/> Hygiene <input type="checkbox"/> Other: _____ _____	<input type="checkbox"/> Developing natural supports <input type="checkbox"/> Conflict resolution <input type="checkbox"/> Boundary awareness <input type="checkbox"/> Communication skills <input type="checkbox"/> Other: _____ _____	<input type="checkbox"/> Money management <input type="checkbox"/> Maintaining living env't <input type="checkbox"/> Cooking/Shopping <input type="checkbox"/> Time management <input type="checkbox"/> Educational supports <input type="checkbox"/> Other: _____ _____	<input type="checkbox"/> Identifying resources <input type="checkbox"/> Housing resources <input type="checkbox"/> Food resources <input type="checkbox"/> Clothing resources <input type="checkbox"/> Academic resources <input type="checkbox"/> Entitlement Application <input type="checkbox"/> Vocational/Job Skill <input type="checkbox"/> Other: _____ _____	<input type="checkbox"/> Psychoeducation <input type="checkbox"/> Coping skill development <input type="checkbox"/> Mental health education <input type="checkbox"/> Emotional Regulation <input type="checkbox"/> Medication management <input type="checkbox"/> Other: _____ _____
Print Name and Credentials			Date of referral	
Signature			Phone number	
Clinical Supervisor, as applicable				

Please fax or email completed referral to

Fax: 410-824-1237

Email: customercare@augustrosehc.com

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 Glen Burnie, MD 21061
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