Adult PRP Referral Form

Referral Source

Name:			**Affiliated Clinic:**		
Address:					
Phone number:		**Fax:**		**Email address:**	

Client Information

Name:		**DOB:**		**Gender identity**		**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?**	○ **Weekly** ○ **Biweekly** ○ **Monthly** **Other**

Please provide dates of last 4 provider sessions with client:	**Date:**	**Date:**	**Date:**	**Date:**
Is the participant prescribed medication?	**Yes Or No**			
Are any of the medications prescribed for MDD (Major Depressive Disorder) or Bipolar?	**Yes No N/A**			

Medication Name	**Dosage**	**Frequency**

Is the primary reason for the participant's impairment due to an organic process or syndrome, intellectual disability, a neurodevelopmental disorder or neurocognitive disorder (e.g., dementia, autism, stroke, brain injury)?*	**Yes No Not applicable**
Substance Abuse History	**Yes Or No** ***If Yes, Indicate Substance(s) of choice:***
Suicidal	**Yes Or No** ***If Yes, Indicate history:***
Homicidal	**Yes Or No** ***If Yes, Indicate history:***

Qualifying Adult Diagnosis
(Must be at least one of the following)

Category A Diagnosis- Must meet either criteria 1 or 2 under "Additional Service Criteria Requirements" listed below.

- ○ **F20.81 Schizophreniform Disorder**
- ○ **F20.9 Schizophrenia**
- ○ **F22 Delusional Disorder**
- ○ **F25.0 Schizoaffective Disorder, Bipolar Type**
- ○ **F25.1 Schizoaffective Disorder, Depressive Type**
- ○ **F29 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder**
- ○ **F31.2 Bipolar I Disorder, Current or MRE Manic, /w Psychotic Features**
- ○ **F31.5 Bipolar I disorder, Current or MRE Depressed, /w Psychotic Features**
- ○ **F33.3 MDD, Recurrent Episode, /w Psychotic Features**
- ○ **F28 Other Specified Schizophrenia Spectrum and other Psychotic Disorder**

Category B Diagnosis- Must meet criteria #2 under "Additional Service Criteria Requirements" listed below.

- ○ **F31 Bipolar I Disorder, Current or most recent episode Hypomanic**
- ○ **F31.13 Bipolar I Disorder, Current or Most recent episode Manic, Severe**
- ○ **F31.4 Bipolar I Disorder, Current or most recent episode Depressed, Severe**
- ○ **F31.81 Bipolar II Disorder, Unspecified**
- ○ **F31.9 Unspecified Bipolar and Related Disorder**
- ○ **F33.2 Major Depressive Disorder, Recurrent Episode, Severe**
- ○ **F60.3 borderline personality disorder**
- ○ ____________________
- ○ ____________________
- ○

Additional Service Criteria Requirements
Please check all that apply.

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- ○ **The individual is enrolled in SSI or SSDI**
- ○ **The referred individual demonstrates impaired functioning for at least two years as evidenced by at least 3 of the following criteria on a continuing or intermittent basis. Please include specifics.**
  - ○ **Marked inability to establish or maintain independent competitive employment.**
  - ○ **Marked inability to perform instrumental activities of daily living (Shopping, meal prep, household chores, med management, transportation, money management)**
  - ○ **Marked inability to establish or maintain personal support system.**
  - ○ **Marked or frequent deficiencies of concentration, persistence, or pace**
  - ○ **Marked inability to perform or maintain self-care (hygiene, grooming, nutrition, medical care, personal safety)**
  - ○ **Marked deficiencies in self-direction.**
  - ○ **Marked inability to procure financial assistance to support community living.**
- ○ **Individual does not have two years of impaired functioning as required for a category B diagnosis, but they have a new onset category A diagnosis and PRP services are the most effective means to diminish risk.**

Please indicate previous and current service (s) as applicable:	
Have peer support and other informal supports such as family been tried?	**Yes Or No**
Has Targeted Case Management been tried?	**Yes Or No**
Has group therapy been tried?	**Yes Or No**
Has Supported employment services been tried?	**Yes Or No**
Why is ongoing outpatient treatment not sufficient to address concerns?	

Requested Services (Check all that apply)				
Self-Care Skills	**Social Skills**	**Independent Living Skills**	**Community integration**	**Symptom Management**
Hygiene ○ **Nutrition** ○ **Physical Health** ○ **Personal safety**	○ **Developing supports** ○ **Conflict resolution** ○ **Boundary awareness** ○ **Communication skills**	○ **Money management** ○ **Maintaining living env't** ○ **Cooking/Shopping** ○ **Time management**	○ **Identifying resources** ○ **Entitlement Application** ○ **Vocational/Job Skill** ○ **Recreational/leisure activities** ○	○ **Psychoeducation** ○ **Coping skill development** ○ **Mental health education** ○ **Emotional Regulation**

Print Name and Credentials		**Date of referral**	
Signature		**Phone number**	
Supervisor Name and credentials			

August Rose Health Center

Together. We Rise

Please provide a copy of the most recent diagnostic evaluation and individual treatment plan (ITP).

Please fax or email completed referral to

Fax: 410-824-1237

Email: customercare@augustrosehc.com

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