



**August Rose Health Center, LLC
Child and Adolescent PRP Referral**

Name				Gender	<input type="radio"/> Male	<input type="radio"/> Female	<input type="radio"/> Transgender
Address							
Phone	Home:	Cell:	Work:				
D.O.B.		SSN		MA #	Active insurance: Y or N		
Race				Marital Status			
Attending school?	<input type="radio"/> Yes	<input type="radio"/> No	Current School				Grade level

Legal Guardian/Caregiver

**Please provide documentation for custody as applicable*

Name			Relationship to client	
Contact information	Address:			
	Phone:			

Current mental health provider

Name				Affiliated Clinic	
Address					
Phone		Fax		Email	
How long has client been in treatment with this clinician/psychiatrist?					
Diagnosis <i>(please include secondary as applicable)</i>	Primary:				
	Secondary:				
Substance Abuse	<input type="radio"/> Yes <input type="radio"/> No <i>If yes, indicate substance(s) of choice:</i>				
Suicidal	<input type="radio"/> Yes <input type="radio"/> No <i>If yes, indicate history:</i>				
Homicidal	<input type="radio"/> Yes <input type="radio"/> No <i>If yes, indicate history:</i>				

<p>Provide a brief description of the reason for referral to PRP.</p> <p><i>Select specific area(s) of need below.</i></p>	
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<p><u>Self-Care Skills</u></p> <ul style="list-style-type: none"> <input type="radio"/> Personal hygiene <input type="radio"/> Nutrition <input type="radio"/> Physical activity <input type="radio"/> Personal safety 	<p><u>Social Skills</u></p> <ul style="list-style-type: none"> <input type="radio"/> Developing supports <input type="radio"/> Conflict resolution <input type="radio"/> Boundary awareness <input type="radio"/> Interactive skills 	<p><u>Independent Living Skills</u></p> <ul style="list-style-type: none"> <input type="radio"/> Money management <input type="radio"/> Maintaining living env't <input type="radio"/> Cooking/Shopping <input type="radio"/> Time management 	<p><u>Community Living Skills</u></p> <ul style="list-style-type: none"> <input type="radio"/> Identifying resources <input type="radio"/> Entitlements <input type="radio"/> Housing <input type="radio"/> Vocational 	<p><u>Symptom Management</u></p> <p>Coping Skills for:</p> <ul style="list-style-type: none"> <input type="radio"/> Anger <input type="radio"/> Anxiety <input type="radio"/> Grief and loss <input type="radio"/> Other:
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REFERRED BY

Print Name & Credentials		Date of Referral	
Signature		Phone Number	