August Rose Health Center
Together, We Rise

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

Child and Adolescent PRP Referral
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?**	○ **Weekly** ○ **Biweekly** ○ **Monthly** **Other**

Please provide dates of last 4 provider sessions with client:	**Date:**	**Date:**	**Date:**	**Date:**
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 Diagnosis

ICD-10 Primary Diagnosis Code:*

Primary:

Secondary:

Other:

7477 Baltimore Annapolis Road Suite 201
Glen Burnie, MD 21061
Ph: (410) 412-7791 Fax: (410) 412-7793

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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
○ Nutrition ○ Physical Health ○ Personal safety ○ Hygiene ○ Other:_____ _____	○ Developing natural supports ○ Conflict resolution ○ Boundary awareness ○ Communication skills ○ Other:_____ _____	○ Money management ○ Maintaining living env't ○ Cooking/Shopping ○ Time management ○ Educational supports ○ Other:_____ _____	○ Identifying resources ○ Housing resources ○ Food resources ○ Clothing resources ○ Academic resources ○ Entitlement Application ○ Vocational/Job Skill ○ Other:_____	○ Psychoeducation ○ Coping skill development ○ Mental health education ○ Emotional Regulation ○ Medication management ○ Other:_____

Print Name and Credentials		**Date of referral**	
Signature		**Phone number**	
Clinical Supervisor, as applicable			

Please fax or email completed referral to

Fax: 410-412-7793

Email: customercare@augustrosehc.com

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