August Rose Health Center
Together. We Rise

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?**	☐ **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 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**

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- ☐ 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

- ☐ 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.

Requested Services (Check all that apply)

Self-Care Skills	Social Skills	Independent Living Skills	Community Resources Coordination	Symptom Management
☐ Hygiene	☐ Developing supports	☐ Money management	☐ Identifying resources	☐ Psychoeducation
☐ Nutrition	☐ Conflict resolution	☐ Maintaining living env't	☐ Entitlement Application	☐ Coping skill development
☐ Physical Health	☐ Boundary awareness	☐ Cooking/Shopping	☐ Vocational/Job Skill	☐ Mental health education
☐ Personal safety	☐ Communication skills	☐ Time management		☐ Emotional Regulation

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Ph: (410) 412-7791 Fax: (410) 412-7793

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

Please fax or email completed referral to

Fax: 410-412-7793

Email: customercare@augustrosehc.com

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