Adult Psychiatric Rehabilitation Program Referral Form

Date: **Referring Agency/Address:**

Therapist Name: **Licensure Level:** **Phone:**

Fax: **Email:**

ONCE THIS FORM HAS BEEN COMPLETED AND SIGNED, EMAIL TO: PRPREFERRALS@THEOGC.ORG

Consumer Name: **Gender:** **DOB:**

Medical Assistance #: **Race:**

Address: **Zip:**

Phone: **Email:**

1. **Is the individual currently enrolled in SSI/SSDI?** ☐ **Yes** ☐ **No** ☐ **Unknown**
2. **Is the individual eligible for full funding Developmental Disabilities Administration services?**
   ☐ **Yes** ☑ **No**
3. **Is the primary reason for the individual's impairment due to an organic process or syndrome, intellectual disability, a neurodevelopmental disorder, or neurocognitive disorder?**
   ☐ **Yes** ☑ **No**
4. **Behavioral Diagnosis** (***Please use the current DSM V, ICD-10 diagnoses)***
   F **Date:**
   Diagnosis given by **Date:**
5. **Has the individual been found not competent to stand trial or not criminally responsible and is receiving services recommended by a Maryland Department of Health Education?**
   ☐ **Yes** ☑ **No**
6. **Is the individual in a Maryland State psychiatric facility with a length of stay of more than 3 months who requires RRP upon discharge?** (**Select No. if an individual is eligible for Developmental Disability Services?**) ☐ **Yes** ☐ **No**
7. **Does this person receive remuneration in any form from the PRP?** ☐ **Yes** ☐ **No**
8. **Duration of current episode of treatment provided to this individual:**
   ☐ **Less than one month** ☐ **2-3months** ☐ **4-6months** ☐ **7-12 months**
   ☐ **More than 12 months**
9. **Current frequency of treatment provided to this individual:**
   ☐ **At least 1x/week** ☐ **At least 1x/2 weeks** ☐ **At least 1x/month**
   ☐ **At least 1x/3 months** ☐ **At least 1x/6 month**
10. **Has this individual received PRP services from another PRP service within the past year?**
    ☐ **Yes** ☐ **No** **If yes, list where:**

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- ☐ **Mobile Treatment/Assertive Community Treatment (ACT)**
- ☐ **Inpatient Psychiatric Treatment**
- ☐ **Residential Crisis**
- ☐ **SUD Intensive Outpatient Program (IOP)Level 2.SUD**
- ☐ **Partial Hospitalization Program (IOP)Level 2.2**
- ☐ **Residential SUD Treatment Service Level 3.3**
- ☐ **Residential SUD Treatment Service Level 3.5**
- ☐ **Residential SUD Treatment Service Level 3.7**
- ☐ **Mental Health Intensive Outpatient Program (IOP)**
- ☐ **Mental Health Partial Hospital Program**
- ☐ **SUD Intensive Outpatient Program (IOP)Level 2.1**

FUNCTIONAL CRITERIA (***Per medical necessity, at least three of the following must be present on a continuing or intermittent basis over the past two years)***

Check all that apply and list objective evidence below, MUST answer ALL questions. If question does not apply, type "NA":

☐ **Marked inability to establish or maintain competitive employment:**

☐ **Marked inability to perform instrumental activities of daily living (e.g. Shopping, meal preparation, laundry, medication management):**

☐ **Marked inability to establish/maintain a personal support system:**

☐ **Deficiencies of concentration/persistence/pace leading to failure to complete tasks:**

☐ **Unable to perform self-care:**

☐ **Marked deficiencies in self direction, shown by inability to plan, initiate, organize, and carry out goal directed activities:**

☐ **Marked inability to procure financial assistance to support community living:**

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DURATION OF IMPAIRMENTS:

- ☐ **Marked functional impairment has been present for less than 2years.**
- ☐ **Marked functional impairment has been limited to less than 3 of the above listed areas.**
- ☐ **Has demonstrated marked impairment functioning primarily due to mental illness in at least three of the areas listed above at least 1-2years.**
- ☐ **Has demonstrated impaired role functioning primarily due to a mental illness for at least 3 years**

ALTERNATIVE SERVICE AND TRANSITION CONSIDERATION:

Consideration has been given to using peer supports and other information supports such a family. List attempts and outcomes of any efforts to serve this individual through less formal means such as peer supports or family: ☐ **Yes** ☐ **No**

If yes, list attempts and outcomes:

Functional impairments can be safely addressed at the PRP level of care: ☐ **Yes** ☐ **No**

If yes, list specific ways in which PRP services are expected to help this individual:

COLLABORATION AGREEMENT

I, (*Therapist Name and Title*), agree to participate in team treatment planning sessions/initial session within two weeks of receipt of the referral and quarterly sessions in person or by phone.

Therapist Signature: **Date:**

For OGC Only
Date Referral Received:
Received By:

Staff Signature: **Date:**

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