Referral for Psychiatric Rehabilitation Program (Adult-PRP)

Referral Source Information

☐ Initial ☐ Re-Referral

Name of Clinician / Agency Making Referral			Date of Referral		
Street Address			City	State	Zip Code
Phone	Email				
Mental Health Treatment Being Provided	☐ Outpatient Mental Health Services	☐ Inpatient Mental Health Services	☐ Residential Treatment Center		

Demographic Information

Name	Date of Birth		Age	Medicaid Number
Full Address ☐ Homeless	City	State	Zip Code	Phone
Language Preference	Email			

Employed	Race/Ethnicity
☐ Yes ☐ No	☐ Amer. Indian/Alaskan Native ☐ Asian ☐ White ☐ Hispanic ☐ Non-Hispanic ☐ Black/African American ☐ Native American/ Hawaiian or Other Pacific Islander

Seeking Employment	Veteran Status	Criminal History	Highest Level of Education:
☐ Yes ☐ No	☐ Veteran ☐ Non-Veteran	☐ Yes ☐ No	

Guardian (if applicable)

Name		Relationship	Does Contact Person Have Legal Custody?		
		☐ Parent ☐ Guardian ☐ Forster Care Provider	☐ Yes ☐ No		
Street Address (if different)	City		State	Zip Code	Phone

Rehabilitation Services Needed (Indicate the areas you want the PRP to address)

Self-care skills

- ☐ Personal hygiene
- ☐ Grooming
- ☐ Nutrition
- ☐ Dietary planning
- ☐ Food preparation
- ☐ Self administration of medication

Social skills

- ☐ Community integration activities
- ☐ Developing natural supports
- ☐ Developing linkages with and supporting the individual's participation in community activities

Independent living skills

- ☐ Skills necessary for housing stability
- ☐ Community awareness
- ☐ Mobility and transportation skills
- ☐ Money management
- ☐ Accessing available entitlements and resources
- ☐ Supporting the individual to obtain and retain employment
- ☐ Health promotion and training
- ☐ Individual wellness self-management and recovery

Part One

1. Duration of current episode of treatment provided to this individual**

☐ Less than one month ☐ 2-3 months ☐ 4-6 months ☐ 7-12 months ☐ More than 12 months

2. Current frequency of treatment provided to this individual:**

☐ At least 1 x/week ☐ At least 1 x/2 weeks ☐ At least 1 x/month ☐ At least 1 x/3 months ☐ At least 1 x/6 months

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Current Medications (Please provide name and dosage amount)

Name - Dose - Directions	Name - Dose - Directions	Name - Dose - Directions

Is the individual med compliant

☐ Yes ☐ No

Diagnosis (Please indicate current DSM V diagnosis by checking the appropriate box below)

CATEGORY A

- ☐ F20.0 Paranoid Schizophrenia
- ☐ F20.l Disorganized Schizophrenia
- ☐ F20.2 Catatonic Schizophrenia
- ☐ F20.3 Undifferentiated Schizophrenia
- ☐ F20.5 Residual Schizophrenia
- ☐ F20.81 Schizophreniform Disorder
- ☐ F20.89 Other Schizophrenia
- ☐ F20.9 Schizophrenia, Unspecified
- ☐ F25.0 Schizoaffective Disorder, Bipolar Type
- ☐ F25.l Schizoaffective Disorder, Depressive Type
- ☐ F25.8 Other Schizoaffective Disorders
- ☐ F25.9 Schizoaffective Disorder, Unspecified
- ☐ F22 Delusional Disorder
- ☐ F28 Other Psychotic Disorder
- ☐ F29 Unspecified Psychosis
- ☐ F31.2 Bipolar I Disorder, Manic, Severe w/ Psychotic ft.
- ☐ F31.5 Bipolar I d/o, Depressed, Severe w/ Psychotic ft.
- ☐ F31.64 Bipolar I d/o, Mixed, Severe w/ Psychotic ft.
- ☐ F33.3 MOD, recurrent, severe w/ Psychotic ft.

CATEGORY B (If box is checked, answer questions below)

- ☐ F31.0 Bipolar I, Hypomanic
- ☐ F31.13 Bipolar I, Manic, Severe
- ☐ F31.4 Bipolar I, Depressed, Severe
- ☐ F31.63 Bipolar I d/o, Mixed, Severe w/o Psychotic
- ☐ F31.81 Bipolar II Disorder
- ☐ F31.9 Bipolar I, Unspecified
- ☐ F33.2 MOD, Recurrent Episode, Severe
- ☐ F60.3 Borderline Personality Disorder

If Category A diagnosis, is the Individual Served currently receiving SSI or SSDI? ☐ Yes ☐ No

Diagnosis given by ______________________ Date ______________

Severity of Illness (last 30 days) **and Presenting Symptoms** (please document the individual's current clinical state)

History of Presenting Illness (HPI)

Attach a copy of the current Treatment Plan and Clinical Assessment.

PRP Staff: Date Referral and Assessment Received ______________ Coordinator Assigned ______________

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Functional Criteria

Per medical necessity criteria, **at least three** of the following must have been present on a continuing or intermittent basis over the past two years. Please check the appropriate boxes.

Functional Impairment(s)

- ☐ Marked inability to establish or maintain competitive employment.
- ☐ Marked inability to perform instrumental activities of daily living (eg: shopping, meal preparation, laundry, basic housekeeping, medication management, transportation, and money management).
- ☐ Marked inability to establish/maintain a personal support system.
- ☐ Marked or frequent deficiencies of concentration/ persistence/pace leading to failure to complete tasks.
- ☐ Marked inability to perform self-care (hygiene, grooming, nutrition, medical care, safety.
- ☐ 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.

Duration of Impairment(s)

Have marked functional impairment been present for **at least two years?**

☐ Yes ☐ No

If No, does the participant have a new onset (within past six months) Category A diagnosis?

☐ Yes ☐ No

Intensity of Services Required (Please be concise and report justification for PRP services)

Current Treatment

Please list the locations, dates, responsible parties and phone numbers of inpatient or outpatient settings in which the consumer currently participates. Please include current therapeutic services, as well.

1. ______________________________

2. ______________________________

Mental Health Practitioner

Name	Date
Signature	Date

Supervisor (if needed)

Name	Date
Signature	Date

Who diagnosed the client? ☐ Mental Health Practitioner ☐ Supervisor

Attach a copy of the current Treatment Plan and Clinical Assessment.

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