

**Adult PRP Referral Form**

**Date of Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Referral Received by PRP \_\_\_\_\_\_\_\_\_\_**

**Client Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Medical Assistance #: \_\_\_\_\_\_\_\_\_\_\_**

**M  F Race:** ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age: \_\_\_\_\_\_\_**

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**State:** \_\_\_\_\_\_ **ZIP:** \_\_\_\_\_\_\_\_\_\_\_

**Home Phone:** \_\_\_\_\_\_\_\_**Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please indicate current diagnoses:**

**DSM-IV-TR/DSM-5 Code(s):** \_\_\_\_\_\_\_\_\_\_

**DSM-IV Diagnosis(s):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Summary/Justification:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Is there documentation attached to verify this diagnosis? (Check One) \_X\_Yes \_\_\_\_\_\_No**

**Is the client currently receiving therapy? (Check One) \_\_X\_\_\_\_\_Yes \_\_\_\_\_\_No**

**Reason for Referral (check all that apply):**

Behavior/Conduct Challenges Emotional/Mental Illness  Educational Challenges Employment Instability

Financial Instability Legal/Incarceration Medication Mismanagement Physical/Emotional Abuse

Relational Conflicts Sexual Abuse Social/Interpersonal Challenges Substance Abuse Suicidal/Homicidal

**Symptoms and Behaviors/Risk Behaviors (check all that apply):**

Anxiety/Panic Attachment Problems Depressed Fire Setting Homicidal Ideations Hopeless/Helpless  Hyperactive ImpulsiveIrritable Isolative Lying/Manipulative Manic MoodObsession/CompulsionOppositional Defiant Physical Aggression Property Destruction Running Away Self-Care Deficit Self-Injurious BehaviorSeparation Problems Sexually Inappropriate Social/Withdrawal Stealing Suicidal Ideations Trauma-related Truancy Verbal Aggression

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 Evaluator?\*\*

Yes No

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 individual is eligible for Developmental Disabilities Services)\*\*

Yes  No

Is the individual eligible for full funding for Developmental Disabilities Administration services?\*\*

Yes  No

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

**Services Needed (check all that apply):**

Does the participant have marked inability to establish or maintain competitive employment?\*\*

Yes  No

Evidence of marked inability to establish or maintain competitive employment:\*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the participant have marked inability to perform instrumental activities of daily living (eg: shopping, meal preparation, laundry, basic housekeeping, medication management, transportation, and money management)?\*\*

Yes  No

Evidence of marked inability to perform instrumental activities of daily living (eg: shopping, meal preparation, laundry, basic housekeeping, medication management, transportation, and money management):\*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the participant have marked inability to establish/maintain a personal support system?\*\*

Yes  No

Evidence of marked inability to establish/maintain a personal support system:\*

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Does participant have deficiencies of concentration/ persistence/pace leading to failure to complete tasks?\*\*

Yes  No

Evidence of deficiencies of concentration/ persistence/pace leading to failure to complete tasks:\*

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Is the participant unable to perform self-care (hygiene, grooming, nutrition, medical care, safety)?\*\*

Yes  No

Evidence of unable to perform self-care (hygiene, grooming, nutrition, medical care, safety):\*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the participant have marked deficiencies in self-direction, shown by inability to plan, initiate, organize and carry out goal directed activities?\*\*

Yes  No

Evidence of marked deficiencies in self-direction, shown by inability to plan, initiate, organize and carry out goal directed activities:\*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the participant have marked inability to procure financial assistance to support community living?\*\*

Yes  No

Evidence of marked inability to procure financial assistance to support community living:\*

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Duration of Impairment(s):

Has marked functional impairment been present for less than 2 years?\*\*

Yes  No

Has the participant demonstrated marked impaired functioning primarily due to a mental illness in at least three of the areas listed above at least 2 years?\*\*

Yes  No

**Treating, Licensed, Mental Health Professional: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature/License**

**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**