



PRP Referral Form (Adult)

Date of Referral:

Client Name:

Medical Assistance #:

M

F

Race:

DOB:

Age:

Address:

City:

State: MD ZIP:

Home Phone:

Cell Phone/Work:

PLEASE INDICATE CURRENT DIAGNOSES:

Please select the participant's primary diagnosis provided in the referral document from Category A or Category B below:

Category A

Category B

Summary/Justification:

Is there documentation attached to verify this diagnosis? Yes No

Is the client currently receiving therapy? Yes No

REASON FOR REFERRAL /SYMPTOMS AND BEHAVIORS/RISK BEHAVIORS (check all that apply):

Behavior/Conduct Challenges	Anxiety/Panic	Attachment Problems
Emotional/Mental Illness	Depressed	Fire Setting
Educational Challenges	Homicidal Ideations	Hopeless/Helpless
Employment Instability	Hyperactive	Impulsive
Financial Instability	Irritable	Isolative
Legal/Incarceration	Lying/Manipulative	Manic Mood
Medication Mismanagement	Obsession/Compulsion	
Physical/Emotional Abuse	Oppositional Defiant	
Relational Conflicts	Physical Aggression	Property Destruction
Sexual Abuse	Running Away	Self-Care Deficit
Social/Interpersonal Challenges	Self-Injurious Behavior	
	Separation Problems	
	Sexually Inappropriate	
	Social/Withdrawal	
	Stealing	
	Suicidal Ideations	Trauma-related
	Truancy	Verbal Aggression

SUBSTANCE ABUSE HISTORY:

IS THERE A HISTORY OF SUBSTANCE ABUSE?

INVOLVED IN SUBSTANCE ABUSE TREATMENT?

Diagnosis Information (Initial Request Only)

1. Is currently taking prescribed medications? Yes No

IF NO, Please explain why the participant is not on medication?

IF YES, Are any of the medications prescribed for MDD (Major Depressive Disorder) or Bipolar ? Yes No N/A

If YES, what medication, dosage, frequency?

IF NO, Please explain why are medication not part of the treatment?

2. 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

(If NO, this referral for services cannot proceed as this individual is NOT eligible for service)

Other Referral Questions (Initial Request Only)

1. Is the individual eligible for full funding for Developmental Disabilities Administration services? Yes No

(If YES, this referral for services cannot proceed as this individual is NOT eligible for service)

2. 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

(If YES, this referral for services cannot proceed as this individual is NOT eligible for service)

Clinical Information

Has an individual treatment plan/rehabilitation plan been complete? Yes No

(IF NO, this referral for services cannot proceed as this individual is NOT eligible for service)

Why is ongoing outpatient treatment not sufficient to address concerns?

SERVICES NEEDED (check all that apply):

Occupational

Is the participant employed? Yes No

IF NO, Does the participant wish to be employed?*

Has the participant been referred to supported employment? Yes No N/A

IF NO, Explain why the participant has not been referred to supported employment?*

Duration of Impairment(s)

1.Has marked functional impairment been present for less than 2 years? Yes No

IF NO, Does participant have a new onset (within past six months)

Category A diagnosis? Yes No

(If no, this referral for services cannot proceed as this individual is NOT eligible for service)

Functional Criteria Select A MINIMUM OF THREE criteria. Please explain how the primary mental health diagnosis delays the client's ability to perform and/or complete the selected criteria.

3. Does the participant have impairments related to the Priority Population diagnosis in three or more of the functional areas listed below? Yes No

A. (If no, this referral for services cannot proceed as this individual is NOT eligible for service)

To understand what is being requested for each of the functional impairments below, a generalized example of a response is provided here:

1. Symptom of Priority Population diagnosis: Paranoia

2. Impairment impacting Functioning: Paranoia results in being suspicious of others.

3. Example of impaired function: Last week he would not get on the bus because he thought the driver was out to get him. He started yelling at the bus driver.

1. Evidence of marked inability to establish or maintain competitive employment?
Yes No

IF YES, Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning

IF YES, Describe how, specifically, these symptoms impair the participant's functioning

IF YES Provide specific concrete examples of THIS participant's impaired function.

2. Does the participant have a marked inability to perform instrumental activities of daily living (eg: shopping, meal preparation, laundry, basic housekeeping, medication management, transportation, and money management)? Yes No

IF YES, Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning

IF YES, Describe how, specifically, these symptoms impair the participant's functioning

IF YES Provide specific concrete examples of THIS participant's impaired function.

3. Does the participant have a marked inability to establish/maintain a personal support system? Yes No

IF YES, Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning

IF YES, Describe how, specifically, these symptoms impair the participant's functioning

IF YES Provide specific concrete examples of THIS participant's impaired function.

4. Does participant have deficiencies of concentration/ persistence/pace leading to failure to complete tasks? Yes No

IF YES, Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning

IF YES, Describe how, specifically, these symptoms impair the participant's functioning

IF YES Provide specific concrete examples of THIS participant's impaired function.

5. Is the participant unable to perform self-care (hygiene, grooming, nutrition, medical care, safety)? Yes No

IF YES, Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning

IF YES, Describe how, specifically, these symptoms impair the participant's functioning

IF YES Provide specific concrete examples of THIS participant's impaired function.

6. Does the participant have marked deficiencies in self-direction, shown by inability to plan, initiate, organize and carry out goal directed activities? Yes No

IF YES, Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning?

IF YES, Describe how, specifically, these symptoms impair the participant's functioning

IF YES Provide specific concrete examples of THIS participant's impaired function.

7. Does the participant have marked inability to procure financial assistance to support community living? Yes No

IF YES, Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning

IF YES, Describe how, specifically, these symptoms impair the participant's functioning

IF YES, Provide specific concrete examples of THIS participant's impaired function.

Status of less Intensive Level of Treatment

1. Have peer supports and other informal supports such as family been tried? Yes No

IF YES, Explain why peer supports and other informal supports have not been sufficient.*

IF NO, What is the reason this has not been tried?

2. Has group therapy been tried? Yes No

IF NO, What is the reason this has not been tried?

3. Has targeted case management been tried? Yes No

IF NO, What is the reason this has not been tried?

Mental Health Professional:

Phone Number:

Supervisor, If Applicable

Verbal Approval from Therapist to refer identified client for Psychiatric Rehabilitation services secured.

Referring Agency