TRI HEARTS LLC.
Counseling Education Fitness

PRP Referral Form (Child)

Date of Referral:

Client Name: **Medical Assistance #:**

☐ **M** ☐ **F** **Race:** **DOB:** **Age:**

Address: **City:** **State: MD** **ZIP:**

Home Phone: **Cell Phone/Work:**

Parent or Legal Guardian **Mother** ☐ **Father** ☐ **Guardian** ☐

PLEASE INDICATE CURRENT DIAGNOSES:

PRIMARY DIAGNOSIS	ADDITIONAL DIAGNOSIS
SELECT A DIAGNOSIS	N/A

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

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. Have family or peer supports been successful in supporting this youth? ☐ 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
   (If YES, this referral for services cannot proceed as this individual is NOT eligible for service)

Clinical Information

1. Is currently taking prescribed medications? ☐ Not Considered
   ☐ Considered and Ruled ☐ Initiate and Withdrawn ☐ Ongoing ☐ Other

IF OTHER, Please explain why?

SERVICES NEEDED (check all that apply):

☐ **Educational Support**: Client needs assistance, education and/or guidance with school behavioral or academic issues

☐ **Health Promotion & Training:** Client needs assistance, education and/or guidance with nutrition, exercise, medication education, substance abuse prevention, prevention of injury,

☐ **Self Care Skills:** Client needs assistance, education and/or guidance personal hygiene/grooming, management of medication, personal safety, nutrition etc.

☐ **Social Skills & Community Support:** Client needs assistance, education and/or guidance with communication, interpersonal skills, developing natural supports, family relationships, friendship/social relations, community participation, etc.

Functional Criteria

Within the past three months, the individual's emotional disturbance has resulted in:

1. A clear, current threat to the youth's ability to be maintained in their customary setting?

   ☐ Yes ☐ No

IF YES, Explain evidence of a clear, current threat to the youth's ability to be maintained in their customary setting:

2. An emerging risk to the safety of the youth or others? ☐ Yes ☐ No

IF YES, Explain evidence of an emerging risk to the safety of the youth or others

3. Significant psychological or social impairments causing serious problems with peer relationships and/or family members? ☐ Yes ☐ No

IF YES, Explain evidence significant psychological or social impairments causing serious problems with peer relationships and/or family members

4. What evidence exists to show that the current intensity of outpatient treatment for this individual is insufficient to reduce the youth's symptoms and functional behavioral impairments resulting from mental illness?
(this referral for services cannot proceed if this questions not answered)

(Complete only for an Initial Request Only)

How will PRP serve to help this youth get to age appropriate development, more independent functioning and independent living skills

(Complete for a Reoccurring Request Only)

Has the youth made progress toward age appropriate development, more independent functioning and independent living skills? ☐ Yes ☐ No

IF YES, describe the improvement

IF NO, indicate changes in treatment plan to address lack of progress:

Has an individual treatment plan/Individual rehabilitation plan been completed?

☐ Yes ☐ No

Has a crisis plan been completed? ☐ Yes ☐ No

Mental Health Professional:

Supervisor, If Applicable

Phone Number:

Referring Agency

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