TRI HEARTS LLC.
Counseling Education Fitness

PRP Referral Form (ADULT)

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:** _____

Parent or Legal Guardian _____ **Relationship (to client)** _____

Phone _____

PLEASE INDICATE CURRENT DIAGNOSES:

DSM-IV-TR/DSM-5 Code(s): _____
DSM-IV Diagnosis(s): _____
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

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

1. 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)

2. 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

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

Treating, Licensed, Mental Health Professional:

Phone Number:

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