REDEFINING THE FUTURE NETWORK

3500 Boston Street, Suite 434, Baltimore Md. 21224 | Phone: 443.429.1981 | Fax: 410.994.4598 | www.rtfnetwork.com

Psychiatric Rehabilitation Service Program Referral Form

Please fax or email the completed referral: 410.994.4598/ referrals@rtfnetwork.com

Referral Source

Referral Date:			
Referring Agency Name and Address:			
Referring Clinician Name and Title:			
Email Address:			
Phone Number:		**Fax Number:**	

Client Information

Clients Name:		**Gender**	
SSN:		**DOB:**	
Age:		**Race:**	
Marital Status:		**MA#**	
Parent(s)/Legal Guardian(s)			
Full Address:			
Phone #		**Alt Phone #**	

Rehabilitation Services Needed:

- ☐ Activities of Daily Living
- ☐ Anger/Temper/Conflict Resolution
- ☐ Assertiveness/Self-esteem
- ☐ Community Activity
- ☐ Family/Natural Supports
- ☐ Finances
- ☐ Home/Housing
- ☐ Self Care Skills
- ☐ Safety to Self/Others
- ☐ School Performance
- ☐ Sexual Issues
- ☐ Social Skills/Peer Interaction
- ☐ Substance Abuse Issues
- ☐ Coping Skills
- ☐ Trauma
- ☐ Medication Compliance Skills
- ☐ Vocational Skills
- ☐ Leisure Skills
- ☐ Work/Job Performance
- ☐ Legal Issues (# of arrests?)
- ☐ Money Management
- ☐ Dietary/Food Preparation
- ☐ Crisis Management Skills
- ☐ Physical Health

History of problems and how will psychiatric rehabilitation assist the client? Why are you referring the client for PRP services? How is the client an emerging risk to himself or others? Does the client have a significant psychological or social impairment causing serious problems with peer relationships and/or family members?

Current Treatment Providers ***(Supervisor's name and credentials needed for LGADC, LGPC and LMSW providers only.)***

Therapist Name:	
Phone #	
Supervisor's Name & Credentials	
Psychiatrist Name:	
Phone #	

Current frequency of treatment provided to this individual.

☐ At least 1x/week ☐ At least 1x/2 weeks ☐ At least 1x/month

The youth has been engaged in active, documented outpatient treatment for:

☐ Less than a month ☐ Between one & three months ☐ Six months or more

In the past three months, how many ER visits has the youth had for psychiatric care?

☐ None ☐ One ☐ Two or more

Is the youth transitioning from an inpatient, day or residential treatment setting to community setting? Yes /No

Diagnosis: please indicate current DSM V diagnoses. **(MUST HAVE AXIS I DIAGNOSIS)**

Axis I:		Axis Code:	
Axis II		Axis Code:	

Diagnosis given by: _____ Date diagnosis given: _____

Medications

Medication Name:	Dosage/Frequency:	Prescribed By:

I,_____(*therapist name and credentials*),

agree to participate in team treatment planning sessions/initial session within two weeks of receipt of the referral and quarterly sessions in person or by phone.

Please Attach Copies of the Following Documents:

1. Current psychosocial, psychiatric, or psychological evaluation
2. Court order (If a child is committed to DSS or DJS)
3. Current therapist's treatment plan

Therapist Signature: _____ Date: _____

(Digital signature acceptable)

Supervisor Signature _____ Date: _____

(Supervisor name required for LGADC, LGPC and LMSW credentials ONLY. Digital signature is acceptable)