Channel Marker
MENTAL HEALTH AND WELLNESS SUPPORT

Building Trust, Hope, and Dignity

ADULT REFERRAL FOR PSYCHIATRIC REHABILITATION PROGRAM

Adult ***Residential*** Referrals-Must contact Midshore Behavioral Health Systems, 410-770-4801, for referral form. All Residential referrals must go through them.

Please send referral and additional clinical information to:

- ☐ Caroline 508 Kerr Ave, Denton, MD 21629 Fax: (410) 820-0124 Phone: (410) 479-2318
- ☐ Dorchester 420 Dorchester Ave, Cambridge, MD 21613 Fax: (410) 221-6459 Phone: (410) 228-8330
- ☐ Talbot 8865 Glebe Park Dr, Unit 2 Easton, MD 21601 Fax: (410) 822-6186 Phone: (410) 822-4611

Channel Marker, Inc. requests clinical information from your agency that supports the necessity for PRP services. Please include with the completed referral the following, as available.

- ☐ Mental Health Treatment Plan (ITP)
- ☐ Social History/Intake/Evaluation
- ☐ Psychological and/or Psychiatric Evaluations
- ☐ Discharge Summaries/Treatment Plans from last placement/hospitalization
- ☐ Medical Evaluations and Developmental History
- ☐ Education/Vocational Evaluations
- ☐ Documentation of Physical Exam within the past 12 months

DEMOGRAPHIC INFORMATION

Name: _____

Date Of Birth: _____ Age _____ Social Security Number: _____

Address: _____ Phone number: _____

Living Arrangement
- ☐ Private Residence/Parent/Guardian
- ☐ Homeless/Shelter
- ☐ Jail/Corrections
- ☐ Treatment
- ☐ Children's Residential
- ☐ Crisis Residence
- ☐ Institutional Setting
- ☐ Residential Care
- ☐ Foster Home
- ☐ Other

If Consumer has a Legal Guardian please list name and address:

_____

Race:
- ☐ White
- ☐ Asian
- ☐ Nat Hawaiian/Other Pacific Islander
- ☐ Black or African American
- ☐ American Indian/Alaskan Native
- ☐ Not Available

Gender: ☐ Male ☐ Female ☐ Transgender Sexual Orientation _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow/Widower

Emergency Contact: _____ Relationship: _____

Address: _____ Phone Number: _____

FINANCIAL INFORMATION

Insurance: ☐ Medicaid ☐ Medicare Insurance number: _____

Current Income: ☐ SSI ☐ SSDI ☐ Employment wages ☐ Other

Amount: _____

EDUCATION/EMPLOYMENT

Education Level:
- ☐ High School Diploma
- ☐ GED
- ☐ Currently enrolled in education
- ☐ Other _____
- ☐ Certificate of Attendance
- ☐ College Degree

If currently enrolled in school anytime in the past three months or schooling was not completed, please provide highest level of grade completed

_____

Education History and Functional Impairments related to Education:

Work History and Functional Impairments related to Competitive Employment:

CLINICAL CRITERIA

Priority Population Diagnosis:

- ☐ F20.0 Paranoid Schizophrenia
- ☐ F20.1 Disorganized Schizophrenia
- ☐ F20.2 Catatonic Schizophrenia
- ☐ F20.3 Undifferentiated Schizophrenia
- ☐ F20.5 Residual Schizophrenia
- ☐ 20.81 Schizophreniform Disorder
- ☐ F20.89 Other Schizophrenia
- ☐ F20.9 Schizophrenia, Unspecified
- ☐ F22 Delusional Disorders
- ☐ F25.0 Schizoaffective Disorder, Bipolar type
- ☐ F25.1 Schizoaffective Disorder, Depressive Type
- ☐ F25.8 Other Schizoaffective Disorders
- ☐ F25.9 Schizoaffective Disorder, Unspecified
- ☐ F28 Other Specified Schizophrenia Spec & Other Psy Disorder
- ☐ F29 Unspec Psychosis not due to a Sub or Known Phys Condition
- ☐ F31.13 Bipolar I Disorder, Current or Most Recent Episode Manic,Severe
- ☐ F31.2 Bipolar I Disorder, Cur or Most Recent Ep Manic, W/ Psy Features
- ☐ F31.4 Bipolar I Disorder, Cur or Most Recent Ep Depr, Sev
- ☐ F31.5 Bipolar I Disorder, Most Recent Epi Dep, With Psy Features
- ☐ F31.0 Bipolar I Disorder, Cur or Most Recent Ep Hypomanic
- ☐ F31.9 Bipolar I Disorder, Cur or Most Recent Ep Unspecified
- ☐ F31.9 Unspecified Bipolar and Related Disorder
- ☐ F31.81 Bipolar II Disorder
- ☐ F33.2 Major Depressive Disorder, Rec Episode Sev
- ☐ F33.3 Major Depressive Disorder, Rec Episode, w/Psych Features
- ☐ F60.3 Borderline Personality Disorder

Medications: _____

Is the client taking medication as prescribed?

☐ Yes ☐ No

TREATMENT AND SERVICE HISTORY

Is individual currently receiving mental health treatment from a licensed mental health professional? ☐ Yes ☐ No

Name, Agency, and Credentials of treating Mental Health Professional:

Name, Agency, and Credentials of Primary Therapist (if different from above):

Name, Agency, and Credentials of Primary Psychiatrist (if different from above):

Frequency of treatment provided to individual

☐ At least 1x a week ☐ At least 1x/2weeks ☐ At least 1x/month ☐ At least 1x/3months ☐ At least 1x/6months

Duration of current episode of treatment provided to individual

☐ Less than 1 mth ☐ 2-3 mths ☐ 4-6 mths ☐ 7-12 mths ☐ More than 12 mths

Number of Psychiatric ER visits or admissions or other crisis episodes in the past 12 months:

Place of occurrence

Reason for occurrence

Is the client currently (or within the past 30 days) participating in any of the following:

☐ Mobile Treatment/Act ☐ Inpatient Psychiatric Treatment ☐ Mental Health IOP
☐ Mental Health Partial Hospitalization ☐ Residential Crisis

Does the individual receive full Developmental Diagnosis funding? ☐ Yes ☐ No ☐ Unknown

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PSYCHIATRIC SYMPTOMS/RISK BEHAVIORS

Suicidal/ Homicidal Threats or Attempts:
☐ In last 30 days
☐ 1-12 months
☐ Over 1 year
Comments:

Self Injurious Behaviors:
☐ In last 30 days
☐ 1-12 months
☐ Over 1 year
Comments:

Chronic Anger/ Aggression:
☐ In last 30 days
☐ 1-12 months
☐ Over 1 year
Comments:

Trauma Related Symptoms:
☐ In last 30 days
☐ 1-12 months
☐ Over 1 year
Comments:

Sexually Inappropriate Behaviors:
- ☐ In last 30 days
- ☐ 1-12 months
- ☐ Over 1 year

Comments:

Runaway Behaviors:
- ☐ In last 30 days
- ☐ 1-12 months
- ☐ Over 1 year

Comments:

CRIMINAL STATUS AND HISTORY

Currently on Probation/Parole/Conditions of Release? ☐ Yes ☐ No

Charges and comments

Is there a Court Order for client to attend PRP?
- ☐ Yes
- ☐ No

Is there a history of criminal charges?
- ☐ Yes
- ☐ No

Charges and comments:

Possession/ Use of Weapons:
- ☐ In last 30 days
- ☐ 1-12 months
- ☐ Over 1 year

Comments:

Fire Setting:
- ☐ In last 30 days
- ☐ 1-12 months
- ☐ Over 1 year

Comments:

SUBSTANCE USE AND HISTORY

Describe Use/ History of Use:

Is client participating in any of the following
- ☐ Residential SUD Treatment Service Level 3.3
- ☐ Residential SUD Treatment Service Level 3.5
- ☐ Residential SUD Treatment Service Level 3.7
- ☐ SUD Intensive Outpatient Program Level 2.1
- ☐ SUD Partial Hospitalization Program Level 2.2

MEDICAL DIAGNOSIS, CONDITIONS, AND NEEDS

Name of Primary Physician

No Primary Physician Known ☐

Medical Conditions (if known):

ACTIVITIES OF DAILY LIVING AND FUNCTIONAL IMPAIRMENTS

Marked inability to perform activities of daily living: ☐ In last 30 days ☐ 1-12 months ☐ Over 1 year

Comments:

Marked inability to establish/maintain personal support system: ☐ In last 30 days ☐ 1-12 months ☐ Over 1 year

Comments:

Deficiencies of concentration/persistence/pace leading to failure to complete tasks: ☐ In last 30 days ☐ 1-12 months ☐ Over 1 year

Comments:

Unable to perform self-care: ☐ In last 30 days ☐ 1-12 months ☐ Over 1 year

Comments:

Deficiencies in self-direction, shown by inability to plan, initiate, organize, and carry out goal-directed activities: ☐ In last 30 days ☐ 1-12 months ☐ Over 1 year

Comments:

Inability to procure financial assistance to support community living: ☐ In last 30 days ☐ 1-12 months ☐ Over 1 year

Comments:

Duration of Impairments:

- ☐ Has been present for less than 2 years
- ☐ Has been limited to less than 3 of the above listed areas
- ☐ Has demonstrated marked impaired functioning primarily due to a mental illness in at least three of the areas listed above at least 2 years
- ☐ Has demonstrated impaired role functioning primarily due to a mental illness for at least 3 years

Consideration has been given to using peer supports and informal supports such as family. List attempts and outcomes of any efforts to serve individuals through these sources.

Comments:

Functional Impairments can be safely addressed at the PRP level of care. List specific ways in which PRP services are expected to help this individual.

Comments:

AUTHORIZATION AND RELEASE OF INFORMATION

I understand that application for rehabilitation services is being made on behalf of me and I agree to this referral for services. I authorize this referring agency to release/exchange information to Channel Marker, Inc. for the purpose of facilitating the referral process. I understand the information exchanged may include diagnosis, evaluations, and progress reports.
In addition, I authorize Channel Marker, Inc. to release/exchange information to Treatment Provider (psychiatrist and therapist) and Emergency Contact for the purpose of facilitating the referral process. I understand I may revoke this consent by written request to Channel Marker, Inc.

Client Signature: Date:

Referring Provider: Credentials: Date:

Signature:

Referring Agency:

Phone Number: Email address: