Channel Marker
MENTAL HEALTH AND WELLNESS SUPPORT

Building Trust, Hope, and Dignity

YOUTH REFERRAL

Please send referral and additional clinical information to:

- ☐ Caroline 613 S Fifth St, Denton, MD 21629 — Fax: (410) 479-0250 Phone: (410) 479-0240
- ☐ 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 records/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 _____

Guardian Name and address _____

Primary Caretaker Name and address _____

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

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 _____

Emergency Contact _____ Relationship _____

Address _____ Phone Number _____

INSURANCE INFORMATION

Insurance: ☐ Medicaid ☐ Medicare Insurance number

EDUCATION

If currently enrolled in school anytime in the past three months please provide highest level of grade completed

Name of School youth attends

Education History and Functional Impairments related to Education

CLINICAL CRITERIA

Diagnosis ICD 10 Code

Diagnosis ICD 10 Code

Diagnosis ICD 10 Code

Diagnosis ICD 10 Code

Has medication been considered for this youth? ☐ Yes ☐ No

Medications:

Name of Primary Physician No Primary Physician Known ☐

MENTAL HEALTH 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 ☐ A least 1x/3months ☐ At least 1x/6months

Duration of current episode of treatment provided to individual ☐ Less than 1 mth ☐ Between 1 and 3 mths ☐ 6 mths or more

Number of Psych ER visits or admissions or other crisis episodes in the past 3 months ☐ 1 ☐ 2+ ☐ N/A

Place of occurrence

Reason for occurrence

Is the currently client participating in any of the following

- ☐ Residential Treatment Center
- ☐ Mobile Treatment Services (MTS/ACT)
- ☐ Development Disability Services
- ☐ Partial Hospitalization Program (PHP)
- ☐ Respite
- ☐ Inpatient Psychiatric Treatment
- ☐ Crisis Residential Services
- ☐ Intensive Outpatient Program (IOP)
- ☐ Therapeutic Behavioral Services (TBS)
- ☐ Targeted Case Management (TCM)

If receiving TCM, name of provider

Is the youth transitioning from inpatient hospital stay or residential treatment setting to the community? ☐ Yes ☐ No

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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 or receiving DJS services? ☐ Yes ☐ No

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

Charges and Comments

Probation/DJS worker contact info

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

MEDICAL DIAGNOSIS, CONDITIONS, AND NEEDS

Medical Conditions (If known)

FUNCTIONAL CRITERIA

Within the past 3 months, the emotional disturbance has resulted in:

Clear, current threat to the youth's ability to be maintained in customary setting.

Comments

Evidence of emerging risk to the safety of youth or others.

Comments

Evidence of significant psychological or social impairments causing serious problems with peer relationships and/or family members

Comments

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?

Comments

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

Comments

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

Parent/Guardian Date

Referring Provider Credentials Date

Signature

Referring Agency

Phone Number Email address