



**Building Communities Today For Tomorrow, Inc.**  
***“Real Issues Deserve Real Work”***



**PSYCHIATRIC REHABILITATION PROGRAM**  
**PROGRAM REFERRAL FORM**

**REFERRAL SOURCE INFORMATION**

Date of Referral: \_\_\_\_\_ Referring Agency: \_\_\_\_\_

Worker (title and credentials): \_\_\_\_\_ Phone: \_\_\_\_\_

Fax Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

**CLIENT INFORMATION**

Consumer Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ RACE: \_\_\_\_\_

Medical Assistance #: \_\_\_\_\_ Legal Guardian: \_\_\_\_\_

Full Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Employer/School: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Rehabilitation Services Needed:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Coping Skills                  | <input type="checkbox"/> Assertiveness/Self-esteem | <input type="checkbox"/> Adult Vocational/Educational Skills |
| <input type="checkbox"/> Social Skills/Peer Interaction | <input type="checkbox"/> Behavior Interventions    | <input type="checkbox"/> School Performance                  |
| <input type="checkbox"/> Medication Monitoring          | <input type="checkbox"/> Onsite Group              | <input type="checkbox"/> Other _____                         |

**Current Treatment:** Please list the locations, dates, responsible parties and phone numbers of inpatient or outpatient settings in which the consumer currently participate.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Diagnosis:** Please indicate current ICD 10 - DSM V diagnoses.

ICD 10 Code: \_\_\_\_\_ DSM V Code: \_\_\_\_\_

ICD 10 Code: \_\_\_\_\_ DSM V Code: \_\_\_\_\_

ICD 10 Code: \_\_\_\_\_ DSM V Code: \_\_\_\_\_

**Diagnosis given by:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Medications** (Please provide name and dosage amount)

\_\_\_\_\_  
\_\_\_\_\_

**\*Please forward the most recent assessment and/or treatment plan when sending this referral. \***

Printed Name and Credentials: \_\_\_\_\_

**Date:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Date Received:** \_\_\_\_\_ **Coordinator Assignment Date:** \_\_\_\_\_ **Authorization Date:** \_\_\_\_\_

**Approved:**  **Denied:**