

**Child PRP Referral Form**

**Date of Referral: \_\_\_\_\_\_\_\_\_ Date Referral Received by PRP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Medical Assistance #: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**M  F Race:** Black **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age: \_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**. **City:** \_\_\_Baltimore\_\_\_\_**State:** \_MD\_\_\_ **ZIP:** \_\_\_\_\_\_\_\_\_\_\_

**Home Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_Work Phone:**

**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? (Check One) \_\_Yes \_\_\_\_\_\_No**

**Is the client currently receiving therapy? (Check One) \_\_\_\_\_\_Yes \_\_\_\_\_\_No**

Behavior/Conduct Challenges Emotional/Mental Illness  Educational Challenges

Employment Instability  Health/Wellness challenges

Financial Instability Legal/Incarceration Medication Mismanagement Physical/Emotional Abuse

Relational Conflicts Sexual Abuse Social/Interpersonal Challenges Substance Abuse Suicidal/Homicidal

**Symptoms and Behaviors/Risk Behaviors (check all that apply):**

Anxiety/Panic Attachment Problems Depressed Fire Setting Homicidal Ideations Hopeless/Helpless  Hyperactive ImpulsiveIrritable Isolative

Lying/Manipulative Manic MoodObsession/CompulsionOppositional Defiant Physical Aggression Property Destruction Running Away Self-Care Deficit Self-Injurious BehaviorSeparation Problems Sexually Inappropriate Social/Withdrawal Stealing Suicidal Ideations Trauma-related Truancy Verbal Aggression

**Services Needed (check all that apply):**

**Adaptive Equipment & Resources:** Client needs assistance, education and/or guidance with assistive medical health aid equipment, technology and devices; referrals to other resources for individuals with disabilities.

**Educational Support**: Client needs assistance, education and/or guidance with school behavioral or academic issues

**Employment Support:** Client needs assistance, education and/or guidance with obtaining and sustaining employment

**Independent Living Skills:** Client needs assistance, education and/or guidance with securing and maintaining housing, utilizing community resources, transportation and mobility training, money management and budgeting, entitlements, etc.

**Health Promotion & Training:** Client needs assistance, education and/or guidance with nutrition, exercise, medication education, substance abuse prevention, prevention of injury, physical health management, symptom management, etc.

**Housing Support:** Client needs assistance, education and/or guidance with accessing and maintaining housing, subsidized rentals, utility assistance/management, accessing emergency shelter, etc.

**Self Care Skills:** Client needs assistance, education and/or guidance personal hygiene/grooming, management of medication, personal safety, nutrition etc.

**Social Skills & Community Support:** Client needs assistance, education and/or guidance with communication, interpersonal skills, developing natural supports, family relationships, friendship/social relations, community participation, etc.

**Functional Impairment(s):**

Within the past three months, the individual's emotional disturbance has resulted in:\*

A clear, current threat to the youth's ability to be maintained in their customary setting?\*\*

Yes  No

Evidence of a clear, current threat to the youth's ability to be maintained in their customary setting:\*

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

An emerging risk to the safety of the youth or others?\*\* Yes  No

Evidence of an emerging risk to the safety of the youth or others:\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Significant psychological or social impairments causing serious problems with peer relationships and/or family members?\*\* Yes  No

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 resulting from mental illness?\*  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the youth made progress toward age appropriate development, more independent functioning and independent living skills?\*\* Yes  No

Describe the improvement:\*

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

Has a crisis plan been completed with family and/or guardian?\*\* Yes  No

Has an individual treatment plan/Individual rehabilitation plan been completed? Yes  No

**Treating, Licensed, Mental Health Professional: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature/ License Phone Number: ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**