

**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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Summary/Justification:**

**Is there documentation attached to verify this diagnosis? (Check One) \_\_Yes \_\_\_\_\_\_No**

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

[x] Behavior/Conduct Challenges [x] Emotional/Mental Illness [x]  Educational Challenges

 [ ] Employment Instability [x]  Health/Wellness challenges

[ ] Financial Instability [ ] Legal/Incarceration [ ] Medication Mismanagement [ ] Physical/Emotional Abuse

[ ] Relational Conflicts [ ] Sexual Abuse [x] Social/Interpersonal Challenges [ ] Substance Abuse [ ] Suicidal/Homicidal

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

**[ ]** Anxiety/Panic **[ ]** Attachment Problems **[x]** Depressed  **[ ]** Fire Setting  **[ ]** Homicidal Ideations **[x]** Hopeless/Helpless  **[x]**  Hyperactive **[x]** Impulsive **[x]** Irritable **[ ]** Isolative

 **[ ]** Lying/Manipulative **[ ]** Manic Mood **[ ]** Obsession/Compulsion **[ ]** Oppositional Defiant **[x]** Physical Aggression  **[ ]** Property Destruction **[ ]** Running Away  **[ ]** Self-Care Deficit **[ ]** Self-Injurious Behavior **[ ]** Separation Problems  **[ ]** Sexually Inappropriate **[x]** Social/Withdrawal **[ ]** Stealing **[ ]** Suicidal Ideations **[ ]** Trauma-related **[ ]** Truancy **[x]** 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.

[x]  **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.

[x]  **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.

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

[x]  **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:\*

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

Describe the improvement:\*

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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: ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**