EMBRACING TRANQUILITY BEHAVIORAL HEALTHCARE LLC
Developing your peace and positivity to achieve Tranquility

Psychiatric Rehabilitation Program (PRP)

Referral Form Please complete form and return via email info@embracingtranquility.com

Name		Gender	Male ◯ Female ◯ Other ◯
Address			
Phone	Home: Cell: Work:		
D.O.B	SSN	MA#	Active Y N
Race	AA	Marital Status	

LEGAL GUARDIAN /CAREGIVER

Name:		Relationship to Client	
Contact Information: If different than above	Address: Phone:		

CURRENT CLINICIAN/PSYCHIATRIST

Name:		Affiliated Clinic:	**Aleks House**		
Address:					
Phone:		Fax:		Email:	
How long has client been in treatment?					
Diagnosis: (Please include secondary if applicable)	Primary: Secondary:				
Suicidal					
Homicidal					
Substance Abuse					

REASON FOR REFERRAL

Provide a brief description of the reason for referral to PRP Select specific area(s) of need below.				
Self-care Skills ◯ Personal Hygiene ◯ Nutrition ◯ Physical Activity ◯ Personal Safety	**Social Skills** ⓧ Developing Supports ◯ Conflict Resolution ◯ Boundary Awareness ◯ Interactive Skills	**Independent Living Skills** ◯ Money Management ◯ Maintaining Living env't ◯ Cooking / Shopping ◯ Time/ management	**Community Living Skills** ◯ Identifying resources ◯ Entitlements ◯ Housing ◯ Vocational	**Symptom Management** ◯ Anger ◯ Anxiety ◯ Grief and Loss ◯ Other

REFERRED BY

Print Name & Credentials:		Date of Referral:	
Signature:			