Connected Communities
For Behavioral Wellness

PSYCHIATRIC REHABILITATION PROGRAM REFERRAL

If available, please forward: 1) copy of most recent Diagnostic Evaluation or Treatment plan; 2) copy of Legal Document of Guardianship if client is under DSS or DJJ; 3) Therapist 's Reasons for Recommendations for PRP Services.

Name			Gender	○ Male Female ○ Transgender	
Address					
Phone					
D.O.B.		Age		MA #	
Race			Marital Status		
Service being sought	☐ Psychiatric Rehabilitation ☐ Counseling ○ Psychiatry/Medication Management				

LEGAL GUARDIAN/CAREGIVER

Name		Relationship to client	
Contact information *(if different from above)*	Address: Phone:		

CURRENT CLINICIAN/PSYCHIATRIST

Name				Affiliated Clinic	
Address					
Phone		Fax		Email	
How long has client been in treatment with this clinician/psychiatrist?					
Diagnosis *(please include secondary if applicable)*					
Substance Abuse	○ Yes ● No *If yes, indicate substance(s) of choice:*				
Suicidal/Homicidal	○ Yes ● No *If yes, indicate history:*				

REASON for REFERRAL

Brief description of the reason for referral. ***Select specific area(s) of need below.***				
Self-Care Skills	**Social Skills**	**Independent Living Skills**	**Community Living Skills**	**Coping Skills for:**
○ Personal hygiene	○ Developing supports	○ Money management	○ Identifying resources	○ Anger
○ Nutrition	○ Conflict resolution	○ Maintaining living env't	○ Entitlements	○ Anxiety
○ Physical activity	○ Boundary awareness	○ Cooking/Shopping	○ Housing	○ Grief and loss
○ Personal safety	○ Interactive skills	○ Time management	○ Vocational	○ Other: Depression

REFERRED BY

Print Name & Credentials		Date of Referral	
Signature			
Referral Contact Info			

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