



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	<input type="radio"/> Male	<input type="radio"/> Female	<input type="radio"/> Transgender
Address							
Phone							
D.O.B.		Age		MA #			
Race				Marital Status			
Service being sought	<input checked="" type="checkbox"/> Psychiatric Rehabilitation	<input checked="" type="checkbox"/> Counseling	<input type="radio"/> Psychiatry/Medication Management				

LEGAL GUARDIAN/CAREGIVER

Name			Relationship to client	
Contact information <i>(if different from above)</i>	Address:			
	Phone:			

CURRENT CLINICIAN/PSYCHIATRIST

Name				Affiliated Clinic	
Address					
Phone		Fax		Email	
How long has client been in treatment with this clinician/psychiatrist?					
Diagnosis <i>(please include secondary if applicable)</i>					
Substance Abuse	<input type="radio"/> Yes <input checked="" type="radio"/> No <i>If yes, indicate substance(s) of choice:</i>				
Suicidal/Homicidal	<input type="radio"/> Yes <input checked="" type="radio"/> No <i>If yes, indicate history:</i>				

REASON for REFERRAL

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

REFERRED BY

Print Name & Credentials			Date of Referral	
Signature				
Referral Contact Info				