



PSYCHIARIC 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"/> Nutrition <input type="radio"/> Physical activity <input type="radio"/> Personal safety	<input type="radio"/> Developing supports <input type="radio"/> Conflict resolution <input type="radio"/> Boundary awareness <input type="radio"/> Interactive skills	<input type="radio"/> Money management <input type="radio"/> Maintaining living env't <input type="radio"/> Cooking/Shopping <input type="radio"/> Time management	<input type="radio"/> Identifying resources <input type="radio"/> Entitlements <input type="radio"/> Housing <input type="radio"/> Vocational	<input type="radio"/> Anger <input type="radio"/> Anxiety <input type="radio"/> Grief and loss <input type="radio"/> Other: Depression	

REFERRED BY

Print Name & Credentials			Date of Referral	
Signature				
Referral Contact Info				