

**PSYCHIATRIC REHABILITATION PROGRAM**

# 5411 Old Frederick Rd Suite 4 Baltimore, MD. 21229

T: (410) 744-7900 F: (410) 744-0091

**Referral Form**

|  |  |
| --- | --- |
| **DATE OF REFERRAL:** |  |
| **Referring Agency/Address:** |  |
| **Referring Worker (title and credentials):** |  | **Phone** |  |
| **Email Address:** |  | **Fax Number:** |  |

**Client Name: Medical Assistance #:**

**SSN**: **M or F Ethnicity: DOB: Age:**

**Address: City: ZIP:**

**Home Phone: Cell Phone: Work Phone:**

**Legal Guardian (if applicable): Relationship (to client) Phone**

**SYMPTOMS AND BEHAVIORS /RISK BEHAVIORS YOU MAY BE EXPERIENCING (check all that apply):**

* Anxiety/Panic
* Attachment Problems
* Bullied by Others
* Depressed
* Disruptive Behaviors
* Fire Setting
* Homicidal Ideations
* Hopeless/Helpless
* Hyperactive
* Impulsive
* Irritable
* Isolation
* Low Self-Esteem
* Lying/Manipulative
* Manic Mood
* Obsession /Compulsion
* Oppositional Defiant
* Physical Aggression
* Poor Concentration
* Poor Hygiene
* Problem Sleeping
* Property Destruction
* Refusal to Comply w/ Rules or requests
* Self-Care Deficit
* Running Away
* Self-Injurious Behavior
* Separation Problems
* Sexually Inappropriate
* Social/Withdrawal
* Stealing
* Sudden Change in Mood/Behavior
* Suicidal Ideations
* Trauma-related
* Truancy
* Verbal Aggression

**Is the client currently receiving therapy? YES NO \_\_**

**Treating Therapist Printed Name: Date: Phone:**

*FOR BFA STAFF USE ONLY*

Dat Date of Referral Received: Received By: Date Referral Source Contacted? Date Client Contacted: Value Options Authorization Date: