

**PSYCHIATRIC REHABILITATION PROGRAM**

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

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**Referral Form Initial Re-Referral**

**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**

**REASON FOR REFERRAL (check all that apply):**

* Adaptive Resources
* Crisis Intervention
* Dangerous Behaviors
* Education-/Vocational Training
* Health Promotion
* Independent Living Skills
* Promotion of Wellness, Self-Management & Recovery
* Recovery Challenges
* Psychiatric Inpatient/Detention Center Support
* Self-Care Skills
* Social Relationships & Leisure Activities
* Social Skills

**SYMPTOMS AND BEHAVIORS/RISK BEHAVIORS (check all that apply):**

* Anxiety/Panic
* Attachment Problems
* Depressed
* Fire Setting
* Homicidal Ideations
* Hopeless/Helpless
* Hyperactive
* Impulsive
* Irritable
* Isolative
* Lying/Manipulative
* Manic Mood
* Obsession/Compulsion
* Oppositional Defiant
* Physical Aggression
* Property Destruction
* Running Away
* Self-Care Deficit
* Self-Injurious Behavior
* Separation Problems
* Sexually Inappropriate
* Social/Withdrawal
* Stealing
* Suicidal Ideations
* Trauma-related
* Truancy
* Verbal Aggression

**Please indicate current DSM-V diagnosis & F-code**

**Diagnosis Code: \_\_\_\_\_\_\_\_ Diagnosis Description:**

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 **Diagnosis given by (print name): → credentials: Date:**

**Is the required psychosocial/diagnostic assessment attached to verify this diagnosis? YES \_ NO \_\_**

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

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

**Therapist Signature: → credentials:**

 I am authorized or have been given authorization to give consent for BFA PRP Team to collaborate with service providers to receive and verify the information on this form for screening assessment purposes, and to determine the appropriateness of services for above-referenced individual.

*FOR BFA STAFF USE ONLY*

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

BFA 2018