Channel Marker
MENTAL HEALTH SUPPORT SERVICES
8865 Glebe Park Drive, Unit 1, Easton, MD 21601
Phone: 410.822.4619 FAX: 410.822.0984
www.channelmarker.org

REFERRAL FORM

SERVICES BEING REFERRED TO:

- ❑ Adult PRP (Caroline County, Dorchester County, Talbot County)
- ❑ Youth PRP (Caroline County, Dorchester County, Talbot County)
- ❑ Transition Age Youth PRP (Caroline County, Dorchester County, Talbot County)
- ❑ Supported Employment (Talbot County)

Adult Residential Referrals - Must contact Mid Shore Mental Health Systems, 410.770.4801, for referral form. All Residential Referrals must go through them.

PLEASE SEND REFERRAL FORM AND ADDITIONAL INFORMATION TO:

❑ Administrative Office
8865 Glebe Park Drive, Unit 1
Easton, MD 21601
410.822.4619 – phone
410.822.0984 – fax
ATTN: Community Liaison Director

❑ Caroline County
508 Kerr Avenue
Denton MD 21629
410.479.2318 – phone
410.820.0124 – fax
ATTN: County Director

❑ Dorchester County
420 Dorchester Avenue
Cambridge MD 21613
410.228.8330 – phone
410.221.6459 – fax
ATTN: County Director

❑ Talbot County
222 Port Street
Easton MD 21601
410.822.4611 – phone
410.822.6186 –fax
ATTN: County Director

To Be Completed by Referral Source:

Channel Marker, Inc. requests clinical information from your agency in order to obtain Value Options authorization to process each referral.

Please include with the completed referral the following, as available:

___ Current Mental Health Treatment Plan (ITP)
___ Current Social History/Intake/Evaluation
___ Current Psychological and/or Psychiatric Evaluation
___ Relevant past social, psychological, and/or psychiatric evaluations
___ Discharge Summaries/Treatment plans from last placement/hospitalization
___ Medical records/evaluations and developmental history
___ Education/Vocational Evaluations
___ Neurological Assessment (if indicated)
___ Documentation of physical examination within the past 12 months

Signature of Referring Psychiatrist or Therapist: _____

Print Name: _____ **Title:** _____

Referring Agency: _____ **Phone Number:** _____

AUTHORIZATION AND RELEASE INFORMATION

I, _____, understand that application for rehabilitation services
Client/Parent or Guardian Printed name
is being made on behalf of me and I agree to this referral for services. I do hereby give permission to Channel Marker, Inc. to provide psychiatric rehabilitation services, including assessment and rehabilitation planning. I authorize _____ to release/exchange information to Channel Marker, Inc. for
Referring Agency
the purpose of facilitating the referral process. I understand the information exchanged may include diagnosis, evaluations, and progress reports.

_____ In addition, I authorize Channel Marker, Inc. to release/exchange information to Treatment Provider
Client Initials
(psychiatrist and therapist) and Emergency Contact for the purpose of facilitating the referral process.

I understand I may revoke this consent by written request to Channel Marker, Inc.

Signed: _____ **Date:** _____
Client/Parent or Guardian Signature

Witness/Staff: _____ **Date:** _____

I. DEMOGRAPHIC INFORMATION

Name: _____ Age: _____ SSN: _____

Address: _____ Phone: _____

Legal Guardian/Relationship to Client (if applicable): _____

Primary Caretaker (if applicable): _____

Date of Birth: _____ Gender: ❑Male ❑Female ❑Transgender

Race: _____ Sexual Orientation: _____

Marital Status: ❑Single ❑Married ❑Separated ❑Divorced

Veteran? ❑Yes ❑No What war? _____ Dates of service: _____

Would the consumer like to be contacted by the Office of MD's Commitment to Veterans for the purpose of Veteran Benefits? ❑Yes ❑No ❑Unknown ❑Already in contact

Is this individual a hurricane victim? ❑Yes ❑No Living situation: _____

Is this individual pregnant? ❑Yes ❑No Number of arrests in past 30 days: _____

Has this individual participated in a self-help group in the past 30 days? ❑Yes ❑No

How well does the consumer speak English? ❑Very Well ❑Well ❑Not Well ❑Not at All ❑Unknown

Does the consumer speak a language other than English? ❑Yes (specify): _____ ❑No ❑Unknown

Emergency Contacts: (Two contacts must be completed for ALL Youth Referrals, one contact for Adult Referrals)

1. Emergency Contact Name: _____ Relationship: _____
   Address: _____ Phone: _____
2. Emergency Contact Name: _____ Relationship: _____
   Address: _____ Phone: _____

Medical Physician: _____ Phone: _____

Address: _____

Psychiatric Physician: _____ Phone: _____

Address: _____

Primary Therapist/Credentials: _____ Phone: _____

Address: _____

II. FINANCIAL INFORMATION

Medicaid Number: _____ Effective Date: _____

Other Insurance Type: _____

Current Entitlements/Amount:

❒ SSI Amount: _____ ❒ SSDI Amount: _____ ❒ Other: _____ Amount:

❒ Employed: Employer: _____

Job Title: _____ Wages: _____/_____

DISABILITY STATUS

Is the consumer deaf or do they have serious difficulty hearing? ❑Yes ❑No ❑Unknown

Is the consumer blind or do they have serious difficulty seeing, even when wearing glasses?
❑Yes ❑No ❑Unknown

Because of a physical, mental, or emotional condition, does the consumer have serious difficulty concentrating, remembering, or making decisions? ❑Yes ❑No ❑Unknown

Does the consumer have serious difficulty walking or climbing stairs? ❑Yes ❑No ❑Unknown

Does the consumer have difficulty dressing or bathing? ❑Yes ❑No ❑Unknown

Because of physical, mental, or emotional condition, does the consumer have difficulty doing errands alone such as visiting a doctor's office or shopping? ❑Yes ❑No ❑Unknown

III. EDUCATION/EMPLOYMENT

School Name/Highest Grade Completed: _____

Diploma: ❑Yes ❑No Certificate of Attendance: ❑Yes ❑No

If currently enrolled in school, Current School Status/Grade: _____

Additional Education/Training: _____

Work History (positions, dates, volunteer or paid):

_____

_____

IV. CLINICAL CRITERIA

Priority Population – ADULTS ONLY (see below for Youth)

- ❑ 295.90/F20.9 Schizophrenia
- ❑ 295.40/F20.81 Schizophreniform Disorder
- ❑ 295.70/F25.0 Schizoaffective Disorder, Bipolar Type
- ❑ 295.70/F25.1 Schizoaffective Disorder, Depressive Type
- ❑ 298.8/F28 Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
- ❑ 298.9/F29 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
- ❑ 297.1/F22 Delusional Disorder
- ❑ 296.33/F33.2 Major Depressive Disorder, Recurrent Episode, Severe
- ❑ 296.34/F33.3 Major Depressive Disorder, Recurrent Episode, With Psychotic Features
- ❑ 296.43/F31.13 Bipolar I Disorder, Current or Most Recent Episode Manic, Severe
- ❑ 296.44/F31.2 Bipolar I Disorder, Current or Most Recent Episode Manic, With Psychotic Features
- ❑ 296.53/F31.4 Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe
- ❑ 296.54/F31.5 Bipolar I Disorder, Most Recent Episode Depressed, With Psychotic Features
- ❑ 296.40/F31.0 Bipolar I Disorder, Current or Most Recent Episode Hypomanic
- ❑ 296.40/F31.9 Bipolar I Disorder, Current or Most Recent Episode Hypomanic, Unspecified
- ❑ 296.7/F31.9 Bipolar I Disorder, Current or Most Recent Episode Unspecified
- ❑ 296.80/F31.9 Unspecified Bipolar and Related Disorder
- ❑ 296.89/F31.81 Bipolar II Disorder
- ❑ 301.22/F21 Schizotypal Personality Disorder
- ❑ 301.83/F60.3 Borderline Personality Disorder
- ❑ Other Diagnoses in addition to the Priority Population Diagnosis: (Please list)

_____

_____

YOUTH DSM-V DIAGNOSIS (see above for Adults)

CODE	DIAGNOSIS

MEDICATIONS (name, dosage, monitoring needs):

_____

_____

_____

Is the client taking medications as prescribed? ❑Yes ❑No Date of last therapy session: _____

V. REASON FOR REFERRAL

What are the goals for PRP/Why is the client being referred?

List client's strengths and areas of interest:

List client's areas of needed improvement:

VI. TREATMENT AND SERVICE HISTORY

History of psychiatric hospitalizations (include dates, hospital, reason, length of stay)

Number of Emergency Room or other crisis episodes in the last 12 months**:**

Number of Inpatient Admissions in the last 12 months: Lifetime Hospitalizations:

Reason for ER visit or Inpatient Admission (if known):

Describe behaviors and/or symptoms which indicate decompensation:

Describe history of criminal records: ❑ N/A

Currently on Probation/Parole/Conditions of Release or involved with DJS: ❑Yes ❑No
If yes, explain charges/convictions:

Is there a Court Order for this client to attend PRP: ❑Yes ❑No
If yes, explain and attach a copy of the order:

Describe Substance Abuse History: ❑ N/A

Describe Medical Conditions that could impact participation/Significant medical history:

VII. RISK BEHAVIOR CHECKLIST

If behaviors have occurred within the last 30 days, provide additional information in the Comment section including date of last occurrence.

Behavior/Problem	**Current (30 days)**	**Within Last 12 Months**	**Over 1 year**
Suicidal/Homicidal Threat/Attempt Comment:			
Self Injurious Behaviors Comment:			
Possession/Use of Weapons Comment:			
Fire Setting Comment:			
Chronic Anger/Aggression (physical, verbal, destruction of property etc.) Comment:			
Trauma Related Symptoms Comment:			
Sexually Inappropriate Behaviors (perpetrator, promiscuous) Comment:			
Social Interpersonal Conflicts Comment:			
Family Problems/Peer Conflicts Comment:			
Coping With Daily Roles & Activities Comment:			
Learning Difficulties/School or Vocational Problems Comment:			
Runaway Behavior Comment:			
Other Behaviors Please Describe:			