Channel Marker
MENTAL HEALTH AND WELLNESS SUPPORT

Building Trust, Hope, and Dignity

REFERRAL FOR CONTINUING CARE FORM

Please send referral and additional clinical information to:

◯ Caroline County	Fax: (410) 820-0124	Phone: (410) 479-2318
◯ Dorchester County	Fax: (410) 221-6459	Phone: (410) 228-8330
◯ Talbot County	Fax: (410) 822-6186	Phone: (410) 822-4611

Name of Client: _____ Date Of Birth: _____

Clinical Criteria

Priority Population Criteria:

- ☐ F20.0 Paranoid Schizophrenia
- ☐ F20.1 Disorganized Schizophrenia
- ☐ F20.2 Catatonic Schizophrenia
- ☐ F20.3 Undifferentiated Schizophrenia
- ☐ F20.5 Residual Schizophrenia
- ☐ F20.81 Schizophreniform Disorder
- ☐ F20.89 Other Schizophrenia
- ☐ F20.9 Schizophrenia, Unspecified
- ☐ F22 Delusional Disorder
- ☐ F25.0 Schizoaffective Disorder, Bipolar Type
- ☐ F25.1 Schizoaffective Disorder, Depressive Type
- ☐ F25.8 Other Schizoaffective Disorders
- ☐ F25.9 Schizoaffective Disorder, Unspecified
- ☐ F28 Other Specified Schizophrenia Spec & Other Psychotic Disorder
- ☐ F29 Unspec Psychosis not due to a subst or known phys condition
- ☐ F31.0 Bipolar I Disorder, Cur or Most Rec Episode Manic, Sever
- ☐ F31.13 Bipolar I Disorder, Cur or Most Recent Episode Manic, Severe
- ☐ F31.2 Bipolar I Disorder, Cur or Most Recent Ep Manic, w/Psych Feature
- ☐ F31.4 Bipolar I Disorder, Cur or Most Recent Ep Depress, Severe
- ☐ F31.5 Bipolar I Disorder, Most Recent Epi Dep, With Psych Features
- ☐ F31.63 Bipolar I Disorder, Mixed, Severe, w/o Psychotic Features
- ☐ F31.64 Bipolar I Disorder, Mixed, Severe w/Psychotic Features
- ☐ F31.81 Bipolar II Disorder
- ☐ F31.9 Bipolar I Disorder, Unspecified
- ☐ F33.2 Major Depressive Disorder, Recurrent Episode, Severe
- ☐ F33.3 Major Depressive Disorder, Rec Episode, w/Psych Features
- ☐ F60.3 Borderline Personality Disorder

Current frequency of treatment provided to this individual: ◯ At least 1x/week ◯ At least 1x/2weeks ◯ At least 1x/month ◯ At least 1x/3months ◯ At least 1x/6months

Client continues to need PRP services: ☐ Yes ☐ No

Supporting Clinical Comments (symptoms, behaviors, functional impairments, etc):

Why is ongoing outpatient treatment not sufficient to address concerns?

Name of Clinician: _____ Credentials of Clinician: _____

Email address: _____ Referring Agency: _____

Signature of Clinician: _____

Date of Continuing Referral: _____

Rv 6.23