Channel Marker

MENTAL HEALTH AND WELLNESS SUPPORT

ADULT REFERRAL FOR PSYCHIATRIC REHABILITATION PROGRAM

Adult ***Residential*** Referrals-Must contact Midshore Behavioral Health Systems, 410-770-4801, for referral form. All Residential referrals must go through them.

Please send referral and additional clinical information to:

Caroline 508 Kerr Ave, Denton, MD 21629	Fax: (410) 820-0124 Phone: (410) 479-2318
Dorchester 420 Dorchester Ave, Cambridge, MD 21613	Fax: (410) 221-6459 Phone: (410) 228-8330
Talbot 8865 Glebe Park Dr, Unit 2 Easton, MD 21601	Fax: (410) 822-6186 Phone: (410) 822-4611

Channel Marker, Inc. requests clinical information from your agency that supports the necessity for PRP services. Please include with the completed referral the following, as available.

- Mental Health Treatment Plan (ITP)
- Social History/Intake/Evaluation
- Psychological and/or Psychiatric Evaluations
- Discharge Summaries/Treatment Plans from last placement/hospitalization
- Medical Evaluations and Developmental History
- Education/Vocational Evaluations
- Documentation of Physical Exam within the past 12 months

DEMOGRAPHIC INFORMATION

Name:

Date Of Birth: Age: Social Security Number:

Address: Phone number:

Living Arrangement
- Private Residence/Parent/Guardian
- Crisis Residence
- Homeless/Shelter
- Institutional Setting
- Jail/Corrections
- Residential Care
- Treatment
- Foster Home
- Children's Residential
- Other

If Consumer has a Legal Guardian please list name and address:

Race:
- White
- Black or African American
- Asian
- American Indian/Alaskan Native
- Nat Hawaiian/Other Pacific Islander
- Not Available

Gender: Male Female Transgender Sexual Orientation

Marital Status: Single Married Separated Divorced Widow/Widower

Emergency Contact: Relationship:

Address: Phone Number:

FINANCIAL INFORMATION

Insurance: Medicaid Medicare Insurance number:

Current Income: SSI SSDI Employment wages Other

Amount:

EDUCATION/EMPLOYMENT

Education Level: High School Diploma | Certificate of Attendance | GED | College Degree | Currently enrolled in education | Other

If currently enrolled in school anytime in the past three months or schooling was not completed, please provide highest level of grade completed

Education History and Functional Impairments related to Education:

Work History and Functional Impairments related to Competitive Employment:

CLINICAL CRITERIA

Priority Population Diagnosis:

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 Disorders
F25.0 Schizoaffective Disorder, Bipolar Type
F25.1 Schizoaffective Dis, Depressive Type
F25.8 Other Schizoaffective Disorders
F25.9 Schizoaffective Disorder, Unspecified
F28 Other Spec Schizophrenia Spec & Other Psych Dis
F29 Unspec Schizophrenia Spec & Other Psych Dis
F31.0 Bipolar I Dis, Cur or Most Rec Episode Hypomanic
F31.13 Bipolar I Dis,Cur or Most Rec Episode Manic, Severe
F31.2 Bipolar I Dis, Cur or Most Rec Episode Manic, With Psychotic Features
F31.4 Bipolar I Dis, Cur or Most Rec Episode Depressed, Severe
F31.5 Bipolar I Dis, Most Rec Episode Depressed With Psychotic Features
F31.63 Bipolar I Dis, Mixed, Severe, Without Psychotic Features
F31.64 Bipolar I Dis, Mixed, Severe w/Psychotic Features
F31.81 Bipolar II Disorder
F31.9 Bipolar I Disorder, Unspecified
F33.2 Major Depressive Dis, Rec Episode Sev
F33.3 Major Depressive Dis, Rec Episode, w/Psych Features
F60.3 Borderline Personality Disorder

Medications:

Is the client taking medication as prescribed? Yes No

TREATMENT AND SERVICE HISTORY

Is individual currently receiving mental health treatment from a licensed mental health professional? Yes No

Name, Agency, and Credentials of treating Mental Health Professional:

Name, Agency, and Credentials of Primary Therapist (if different from above):

Name, Agency, and Credentials of Primary Psychiatrist (if different from above):

Frequency of treatment provided to individual	At least 1x a week At least 1x/6months	At least 1x/2weeks	At least 1x/month	At least 1x/3months
Duration of current episode of treatment provided to individual	Less than one month More than 12 months	2-3 months	4-6 months	7-12 months

Number of Psychiatric ER visits or admissions or other crisis episodes in the past 12 months:

Place of occurrence

Reason for occurrence

Is the client currently (or within the past 30 days) participating in any of the following:	Mobile Treatment/Act Mental Health IOP Residential Crisis	Inpatient Psychiatric Treatment Mental Health Partial Hospitalization

Does the individual receive full Developmental Diagnosis funding? Yes No Unknown

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PSYCHIATRIC SYMPTOMS/RISK BEHAVIORS

Suicidal/ Homicidal Threats or Attempts:	In last 30 days 1-12 months Over 1 year	Comments:
Self Injurious Behaviors:	In last 30 days 1-12 months Over 1 year	Comments:
Chronic Anger/ Aggression:	In last 30 days 1-12 months Over 1 year	Comments:

Trauma Related Symptoms:	In last 30 days 1-12 months Over 1 year	Comments:
Sexually Inappropriate Behaviors:	In last 30 days 1-12 months Over 1 year	Comments:
Runaway Behaviors:	In last 30 days 1-12 months Over 1 year	Comments:

CRIMINAL STATUS AND HISTORY

Currently on Probation/Parole/Conditions of Release? Yes No

Charges and comments

Is there a Court Order for client to attend PRP? Yes No

Is there a history of criminal charges? Yes No

Charges and comments:

Possession/ Use of Weapons:	In last 30 days 1-12 months Over 1 year	Comments:
Fire Setting:	In last 30 days 1-12 months Over 1 year	Comments:

SUBSTANCE USE AND HISTORY

Describe Use/ History of Use:

Is client participating in any of the following	Residential SUD Treatment Service Level 3.3	Residential SUD Treatment Service Level 3.5
	Residential SUD Treatment Service Level 3.7	SUD Intensive Outpatient Program Level 2.1
	SUD Partial Hospitalization Program Level 2.2	

MEDICAL DIAGNOSIS, CONDITIONS, AND NEEDS

Name of Primary Physician: No Primary Physician Known

Medical Conditions (if known):

ACTIVITIES OF DAILY LIVING AND FUNCTIONAL IMPAIRMENTS

Marked inability to perform activities of daily living: In last 30 days | 1-12 months | Over 1 year

Comments:

Marked inability to establish/maintain personal support system: In last 30 days | 1-12 months | Over 1 year

Comments:

Deficiencies of concentration/persistence/pace leading to failure to complete tasks: In last 30 days | 1-12 months | Over 1 year

Comments:

Unable to perform self-care: In last 30 days | 1-12 months | Over 1 year

Comments:

Deficiencies in self-direction, shown by inability to plan, initiate, organize, and carry out goal-directed activities: In last 30 days | 1-12 months | Over 1 year

Comments:

Inability to procure financial assistance to support community living: | In last 30 days | 1-12 months | Over 1 year

Comments:

Duration of Impairments:

- Has been present for less than 2 years
- Has been limited to less than 3 of the above listed areas
- Has demonstrated marked impaired functioning primarily due to a mental illness in at least three of the areas listed above at least 2 years
- Has demonstrated impaired role functioning primarily due to a mental illness for at least 3 years

Consideration has been given to using peer supports and informal supports such as family. List attempts and outcomes of any efforts to serve individuals through these sources.

Comments:

Functional Impairments can be safely addressed at the PRP level of care. List specific ways in which PRP services are expected to help this individual.

Comments:

AUTHORIZATION AND RELEASE OF INFORMATION

I understand that application for rehabilitation services is being made on behalf of me and I agree to this referral for services. I authorize this referring agency to release/exchange information to Channel Marker, Inc. for 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 (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.

Client Signature: Date:

Referring Provider: Credentials: Date:

Signature:

Referring Agency:

Phone Number: Email address: