# 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) 479-0250 | Phone: (410) 479-0240 |
| ☐ Dorchester County Youth | 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

Youth Diagnosis: DSM-V/Fcode:

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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

How long has the client been engaged in active, documented outpatient treatment?
○ Less than one month ○ 2-3 months ○ 4-6 months
○ 7-12 months ○ More than 12 months

Client continues to need PRP services
☐ Yes ☐ No

What evidence exists to show that current intensity of outpatient treatment for this individual is insufficient to reduce the youth's symptoms and functional behavioral impairments resulting from mental illness?

Has the youth made progress towards age appropriate development, more independent functioning and independent living skills? (Elaborate Below)
☐ Yes
☐ No

Describe improvement:

**-Or-**

| | |
|---|---|
| Indicate changes in treatment plan to address lack of progress: | |
| Name and Credentials of Clinician: | |
| Signature of Clinician (must be actual signature): | |
| Date of Continuing Referral: | |