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 Disorders
- ☐ F25.0 Schizoaffective Disorder, Bipolar Type
- ☐ F25.1 Schizoaffective Disorder, Depressive Type
- ☐ F25.8 Other Schizoaffective Disorders
- ☐ F25.9 Schizoaffective Disorder, Unspecified
- ☐ F28 Other psychotic disorder not due to a substance or known physiological condition
- ☐ F29 Unspec Psychosis not due to a subst or known physiological condition
- ☐ F31.0 Bipolar disorder, Current Episode Hypomanic
- ☐ F31.2 Bipolar disorder, current Episode Manic, w/Psychotic Features
- ☐ F31.4 Bipolar disorder, current episode depressed, severe, without psychotic features
- ☐ F31.5 Bipolar disorder, current Episode Depressed, w/Psychotic Features
- ☐ F31.9 Bipolar disorder, Unspecified
- ☐ F31.13 Bipolar disorder, current episode manic w/o psychotic features, sev
- ☐ F31.63 Bipolar disorder, current episode mixed, severe, without psychotic features
- ☐ F31.64 Bipolar disorder, cur episode mixed, severe, w/psychotic features
- ☐ F31.81 Bipolar II Disorder
- ☐ F33.2 Major depressive disorder, recurrent severe w/o psychotic features
- ☐ F33.3 Major depressive disorder, recurrent, severe with psychotic symptoms
- ☐ 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: _____

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