WORTHY MINDS AND HEARTS

A PRP Changing lives

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Treatment Referral

TREATMENT INFORMATION

Client Name:		**Date of Referral:**		**Requested Date of Assessment:**	
Current Address:					
Date of Birth:		**Gender Preference:**		**Marital Status:**	
Phone Number:		**Email Address:**			
Insurance:		**Policy or MA#**			
Current Diagnosis: **Please indicate the current ICD-10 Codes:**					
Reason for Referral: ***(Please explain how the client's diagnosis is a barrier for community integration)***					
Frequency & Severity of Issue:					
Recent Hospitalizations:					
Lethality or Safety Issues					
Relevant Medical Diagnosis:					
Is the individual currently receiving any of the following services:	☐ MOBILE TREATMENT SERVICES ☐ ASSERTIVE COMMUNITY TREATMENT (ACT) ☐ ADULT TARGETED CASE MANAGEMENT (TCM) ☐ INPATIENT METAL HEALTH -RESIDENTIAL TREATMENT CENTER (RTC) ☐ RESIDENTIAL SUD TREATMENT LEVEL 3.3 AND HIGHER SUBSTANCE USE DISORDER ☐ INTENSIVE OUTPATIENT/2.1 ☐ MENTAL HEALTH INTENSIVE OUTPATIENT / PARTIAL HOSPITALIZATION PROGRAM ☐ RESIDENTIAL CRISIS ☐ NONE				

Rehabilitation Services Requested (Please check all that apply)

☐ Relapse Prevention	☐ Adaptive Resources
☐ Age-Appropriate Self-Care Skills	☐ Maintaining Living Space
☐ Social Skills	☐ Maintaining Age-Appropriate Boundaries
☐ Independent Living Skills	☐ Maintaining Personal Safety in the Social Environment
☐ Activities to Support Cultural Interests	☐ Time Management
☐ Conflict Resolution	☐ Nutrition Management
☐ Anger Management	☐ Coping Skills
☐ Financial Education	☐ Interpersonal Skills with Authority Figures
☐ Age-Appropriate Self-Care Skills	☐ Recovery challenges
☐ Educational Support	☐ Emotional regulation skills training
☐ Independent Living Skills	☐ Addressing oppositional and defiant behaviors

I am verifying that continues to need services from our Rehabilitation Program. Services needed include assessment and continued on-site and/or off-site psychiatric rehabilitation services and crisis management. This service is medically necessary to facilitate the client's wellness and recovery and is based on my assessment of need in the following areas: Please check all that apply.

☐	Inability to establish or maintain employment (pattern of unemployment,	☐	Inability to perform instrumental activities of daily living (shopping, meal preparation laundry, basic

	underemployment, or sporadic work history)		housekeeping, medication management, transportation, and money management
☐	Inability to establish or maintain personal relationships (social withdrawal or isolation, interpersonal conflict or social behavior, other than criminal that is not easily tolerated by the community)	☐	Inability to perform or maintain self-care (hygiene, grooming, nutrition, medical are, personal safety)
☐	Deficiencies in self-direction (inability to independently plan, initiate, organize, and carry out goal directed activities)	☐	Inability to procure financial assistance to support community living

Current Medication

Name of Medication	Dosage	Frequency

Accommodations:	☐ TTY ☐ Interpreter ☐ Sign Language ☐ Ambulatory Limitations ☐ Other ☐ None
Is the client currently receiving services with another provider?	☐ Yes ☐ No If yes please list the name of the organization and the dates of services

REFERRAL SOURCE INFORMATION

Referral Source Name:		**Referral Source Phone #:**	
Referral Source Credentials		**Referral Source Address:**	

Referral Source Signature:	
Referral Source Printed Name:	
Masters or Graduate Level Supervisor Name if Applicable	
Date:	