**Psychiatric Rehabilitation Program Referral Form**

**To efficiently process referrals, please complete this form in its entirety, sign, date, and send to** [**crystal@everyvoicecounts.business**](mailto:crystal@everyvoicecounts.business?subject=Psychiatric%20Rehabilitation%20Program%20Referral%20Form)

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| REFERRAL SOURCE INFORMATION (Referrals must come from a licensed clinician.  This includes: APRN-PMH, CRNP-PMH, LCADC, LCMFT, LCPAT, LCPC, LCSW-C, MD/DO, PhD/PsyD, LMSW\*, LGPC\*, LGADC\*, LGMFT\*, LGPAT\*.  **\*Supervisor must also co-sign this document**) | |
| Date of Referral |  |
| Referral Source Title/Position |  |
| Referral Source Name |  |
| Agency Name |  |
| Phone Number |  |
| Email Address |  |

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| CLIENT DEMOGRAPHICS | | | | | | | | | | | | | |
| Client Name | | | | | | | | | | | | | |
| Client Medical Assistance Number (required for PRP services) | | | | | | | | | | | | | |
| DOB | | | Age | | | | Last 4 of SSN | | | | Preferred Pronouns | | |
| Ethnicity/Race | | | | | | | | Primary Language | | | | | |
| Marital Status | \_\_Single | | | | \_\_Married | | \_\_Divorced | | | \_\_Separated | | \_\_Widow | \_\_Partnered |
| Veteran \_\_Yes \_\_No | | | | | | If yes, what is the year of discharge? | | | | | | | |
| Current Full Address | | | | | | | | | | | | | |
| Check here if homeless \_\_\_ | | | | | | | | | | | | | |
| Contact Numbers | | | | Home | | | | | Cell | | | Work | |
| Email Address | | | | | | | | | | | | | |
| Accommodations | | \_\_ TTY \_\_Interpreter \_\_Sign Language \_\_Ambulatory Limitations \_\_Other | | | | | | | | | | | |
| Client Diagnosis\* | |  | | | | | | | | | | | |
| How long has client been in therapy? | | | | | | | | | | | | | |
| How often is the client seen? | | | | | | | | | | | | | |
| If a client has a substance abuse history, please provide the following:  Drug of choice--including alcohol:  age of first use:  date of last use:  frequency of use:  Frequency of support groups: | | | | | | | | | | | | | |

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| Client’s Current Medication | | |
| Name of Medication | Dosage | Frequency |
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| FOR MINORS ONLY— Functional Impairment Areas (The impairment as a result of the client’s mental illness) | | |
|  | YES | NO |
| A clear, current threat to the client’s ability to be maintained in customary setting |  |  |
| An emerging/pending risk to the safety of the client and others |  |  |
| Evidence of significant psychological/social impairment causing serious problems with peer relationships and/or family members |  |  |
| The client, due to the dysfunction, is at-risk for requiring a higher level of care, or is returning from a higher level of care |  |  |
| The client’s requires an integrated program of rehabilitation services to develop and restore independent living skills to support their recovery |  |  |
| Please provide 1-2 concrete examples of how the symptoms from the client’s diagnosis cause a psychological/social impairment. | | |

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| FOR ADULTS ONLY— Functional Impairment Areas (The impairment as a result of the client’s mental illness) |
| **To qualify for PRP services, adults must be impaired in AT LEAST 3 of the impairment areas** |
| \_\_\_\_\_ marked Inability to establish or maintain employment  \_\_\_\_\_ marked inability to establish/maintain a personal support system  \_\_\_\_\_ marked inability to perform ADL’s satisfactorily  \_\_\_\_\_ deficiencies with concentration/persistence/pace leading to failure to complete tasks  \_\_\_\_\_ marked inability to perform instrumental activities of daily living? (e.g., shopping, meal preparation, money management)  \_\_\_\_\_ unable to perform self-care (hygiene, grooming, nutrition, medical care, safety  \_\_\_\_\_ marked deficiencies in self-direction, shown by inability to plan, initiate, organize, and implement  \_\_\_\_\_ marked inability to procure financial assistance to support community living |
| Please provide 1-2 concrete examples of how the symptoms from the client’s diagnosis cause impairment in the three selected areas. |

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| REHABILITATION SERVICES REQUESTED | | | |
| \_\_Dietary Planning | \_\_Maintaining Personal Living Space | \_\_Age-appropriate Self-care Skills | \_\_ Community Integration Activities |
| \_\_Age-appropriate Boundaries | \_\_Self Administration of Medication | \_\_Maintaining Personal Safety | \_\_Social Skills/Peer Interaction |
| \_\_Physical Health | \_\_Anger Management/ Conflict Resolution Skills | \_\_Grooming/Hygiene | \_\_Family Support Issues |
| \_\_Coping Skills | \_\_Assertiveness/ Self-Esteem | \_\_Developing Natural Supports | \_\_Interactions w/ Peers and/or Authority |
| \_\_Health Promotion & Training | \_\_Community Awareness/ Advocacy | \_\_Time Management | \_\_Individual Wellness, Self-Management, & Recovery |
| \_\_Legal Issues | \_\_School Performance Issues | \_\_Interpersonal Communication Skills | \_\_Accessing Entitlements and other resources |
| \_\_Money Management | \_\_Basic Problem-solving Skills | \_\_Leisure Activities | \_\_Productivity and Self-support |

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| ENTITLEMENT INFORMATION | | |
| SSDI Monthly | Amount | Date Applied |
| SSI Monthly | Amount | Date Applied |
| TANF Monthly | Amount | Date Applied |
| Other Income | Amount | Date Applied |

Upon the clinician’s signature below, the client being referred is appropriate for program services provided by Every Voice Counts. Upon the clinician’s signature below, the client being referred is currently in therapy with their organization.

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| SIGNATURES **(\*If clinician is under supervision, a supervisor must co-sign this document)** | |
| Clinician’s Name (print) | Credentials |
| Clinician’s Signature | Date |
| Supervisor’s Name (print) | Credentials |
| Supervisor’s Agency (if different) | Supervisor’s Signature |
|  | Date |

**Clinical Diagnosis**

**(Client must have at least one of these to qualify for services for adults)**

**\_\_** F 20.9 Schizophrenia, unspecified

\_\_ F 20.0 Paranoid Schizophrenia

\_\_ F 20.1 Disorganized Schizophrenia

\_\_ F 20.2 Catatonic Schizophrenia

\_\_ F 20.3 Undifferentiated Schizophrenia

\_\_ F  20.5 Residual Schizophrenia

\_\_ F 20.81 Schizophreniform disorder

\_\_ F 20.89 other Schiophrenia Spectrum and other Psychotic Disorder

\_\_ F 29 Unspecified Schizophrenia Spectrum and other Psychotic Disorder

\_\_ F 22 Delusional Disorder

\_\_ F 33.2 Major Depressive DO,Recurrent episode,Severe

\_\_ F 33.3 Major Depressive DO, Recurrent, with psychotic features

\_\_ F 31.2 Bipolar 1,Current or Most Recent Manic, with Psychotic features

\_\_ F 31.4 Bipolar 1,current or  Most Recent Depressed, Severe

\_\_ F 31.5 Bipolar 1,Current or  Most Recent, Depressed, with Psychotic features

\_\_ F 31.0 Bipolar 1, Current or Most Recent Hypomanic

\_\_ F 31.9 Bipolar 1,Most Recent Hypomanic, Unspecified

\_\_ F 31.9 Bipolar 1 DO, unspecified

\_\_ F 31.9 Unspecified Bipolar DO

\_\_ F 31.13 Bipolar 1, Current or Most Recent Manic,Severe

\_\_ F 31.63 Bipolar 1, Mixed,Severe, without Psychotic features

\_\_ F 31.64 Bipolar 1, Mixed,Severe with Psychotic features

\_\_ F 31.81 Bipolar ll DO

\_\_ F 21 Schizotypal Personality DO

\_\_ F 60.3 Borderline Personality DO

\_\_ F 25.0 Schizoaffective Disorder, Bipolar type

\_\_ F 25.1 Schizoaffective Disorder, Depressive Type

\_\_ F 25.8 Other Schizoaffective DO

\_\_ F 25.9 Schizoaffective DO Unspecified

\_\_ F 28 other Specified Schizophrenia