**Psychiatric Rehabilitation Program Referral Form (MINOR)**

**\*only available to clients with medicaid\***

**To efficiently process referrals, please complete this form in its entirety, sign, date, and send to** [**info@everyvoicecounts.business**](mailto:info@everyvoicecounts.business)**.**

| 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 |  |
| Referral NPI Number |  |
| Agency Name |  |
| Phone Number |  |
| Email Address |  |

| Client’s Name |  |
| --- | --- |
| Client’s MA Number |  |
| Parent’s Name |  |
| Parent’s Phone Number |  |
| Client’s Address (w/ zip code) |  |
| Client’s DOB |  |
| Client’s Race |  |
| Client’s Sex & Preferred Pronouns |  |
| Client’s Phone Number |  |
| Client’s Grade Level |  |
| Client’s Diagnosis (and code) |  |
| Date client began therapy |  |
| Frequency of sessions |  |
| History of Substance Use? (If Yes, include drug of choice and frequency) |  |

| 1. Why are PRP services needed in conjunction with outpatient services? |
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| 2. How does the client’s symptoms interfere with their emotional and/or psychological development?   * Perceptions * Judgment * Thinking * Mood * Effective self-care * Ability to self-regulate   3. Provide evidence of the impact: |
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| 4. Does the client exhibit any of the following symptoms?   * Hyper-aggression * Increasing acting out behavior * Cutting * Reclusive behavior * Lack of confidence leading to isolation   5. Provide evidence of the symptoms: |
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| 6. Is the client in danger of any of the following?   * Harm to self or others * Being displaced from the place of residence * Being further isolated from friends and family * A deterioration in progress to correct issues of:   + Familial connection   + Interpersonal relationships   7. Why is the client in danger of such a situation? |
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| 8. Is the client showing severe/moderate/mild difficulties in maintaining:   * Positive peer relationships * Healthy interactions with family members * Establishing healthy boundaries * Feelings of worthiness |
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| 9. Any other additional comments to support the reason for referral? |
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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.

| 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 |