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# PRP Referral Form

*If you have any questions regarding this form, please contact pross@avillagewc.com.*

**Initial Referral** ☐ **Concurrent Referral** ☐

| Demographic Information | | | |
|---|---|---|---|
| Name: | DOB: | MA Number: | |
| Address: | | | |
| ☐ Private Residence ☐ Assisted Living ☐ Residential Rehabilitation Program ☐ Shelter ☐ Foster Care | | | |
| Primary Phone: | Work Phone: | Gender Expression: | |
| Race: | Primary Language: | Marital Status: | Military Status: |
| Highest Level of Education: ☐ None ☐ HS/GED ☐ Some College ☐ Bachelors ☐ Masters ☐ Doctorates | | | |
| Employment Status: ☐ Never Employed ☐ Part-Time ☐ Full-Time ☐ Other | | | |
| Preferred Service: ☐ Virtual ☐ Onsite ☐ Hybrid | | | |

**PRP eligibility is restricted to the following ICD-10 diagnoses for Adults (Minors can have any diagnosis). Please check all qualifying diagnoses:**

| | | | |
|---|---|---|---|
| ☐ | F20.0: Paranoid Schizophrenia | ☐ | F29 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder |
| ☐ | F20.1: Disorganized Schizophrenia | ☐ | F31.0: Bipolar I Disorder, Current or Most Recent Episode Hypomanic |
| ☐ | F20.2: Catatonic Schizophrenia | ☐ | F31.13: Bipolar I Disorder, Current or Most Recent Episode Manic, Severe |
| ☐ | F20.3 Undifferentiated Schizophrenia | ☐ | F31.2: Bipolar I Disorder, Current or Most Recent Episode Manic, With Psychotic Features |
| ☐ | F20.5 Residual schizophrenia | ☐ | F31.4: Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe |
| ☐ | F20.81: Schizophreniform Disorder | ☐ | F31.5: Bipolar I Disorder, Current or Most Recent Episode Depressed, With Psychotic Features |

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| | | | |
|---|---|---|---|
| ☐ | F20.89: Other Schizophrenia | ☐ | F31.63 Bipolar I Disorder, Mixed, Severe, Without Psychotic Features |
| ☐ | F20.9: Schizophrenia | ☐ | F31.64 Bipolar I Disorder, Mixed, Severe With Psychotic Features |
| ☐ | F22 Delusional Disorders | ☐ | F31.81: Bipolar II Disorder |
| ☐ | F25.0: Schizoaffective Disorder, Bipolar Type | ☐ | F31.9: Bipolar I Disorder, Unspecified |
| ☐ | F25.1: Schizoaffective Disorder, Depressive Type | ☐ | F33.2: Major Depressive Disorder, Recurrent Episode, Severe |
| ☐ | F25.8: Other Schizoaffective Disorders | ☐ | F33.3: Major Depressive Disorder, Recurrent Episode, With Psychotic Features |
| ☐ | F25.9 Schizoaffective Disorder, unspecified | ☐ | F60.3: Borderline Personality Disorder |
| ☐ | F28: Other Specified Schizophrenia Spectrum and Other Psychotic Disorder | | |
| ☐ | Other (for Minors only): | | |

**Symptoms of Diagnosis (Clinical, please identify specifics):**

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Anxiety | ☐ | Impulsivity | ☐ | Unwanted Thoughts |
| ☐ | Hyperactivity | ☐ | Paranoia | ☐ | Agitated Depression |
| ☐ | Fatigue | ☐ | Guilt | ☐ | Agitation |
| ☐ | Hopelessness | ☐ | Manic Episode | ☐ | Delusion |
| ☐ | General Discontent | ☐ | Elevated Mood | ☐ | Suicidal Ideation |
| ☐ | Disorganized Behavior | ☐ | Restlessness | ☐ | Slowness in Activity |
| ☐ | Irritability | ☐ | Excessive Sleepiness | ☐ | Mood Swings |
| ☐ | Crying Fits | ☐ | Anger Outbursts | ☐ | Hallucinations |
| ☐ | Fight or Flight | ☐ | Self-Isolation | ☐ | Grieving |
| ☐ | Personality Shift | ☐ | Focus Problems | ☐ | Concentration Issues |
| ☐ | Other: | | | | |

**Medical/Mental Health History**

Previous Mental Health Diagnosis:

_____

Is the Client currently participating in Therapy? ☐ **Yes** ☐ **No**

**If Yes, please submit the current Psychosocial Assessment/Diagnostic Assessment**

Name of Therapist:_____

Name of Psychiatrist:_____

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List of current medications:

**SUBSTANCE ABUSE HISTORY:**

IS THERE A HISTORY OF SUBSTANCE ABUSE? ☐ YES ☐ NO

INVOLVED IN SUBSTANCE ABUSE TREATMENT? ☐ YES ☐ NO

IF YES, PLEASE CONFIRM THE PRIMARY SUBSTANCE USED _____

DATE LAST USED _____

**Individual Experiences the following: (Select FOUR criteria and please explain how the primary mental health diagnosis hinders client's ability to perform or complete selected criteria and how long they have been experiencing this if applicable):**

☐ Marked inability to establish or maintain competitive employment

☐ Marked inability to perform instrumental activities of daily living (E.G. SHOPPING, MEAL PREPARATION, LAUNDRY, BASIC HOUSEKEEPING, MEDICATION MANAGEMENT, TRANSPORTATION AND MONEY MANAGEMENT)

☐ Marked inability to establish a personal support system

☐ Deficiencies of concentration/persistence/pace leading to failure to complete tasks

☐ Unable to perform self-care (hygiene, grooming, nutrition, medical care, safety)

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☐ Marked deficiencies in self-direction, shown by inability to plan, initiate, organize, and carry out goal directed activities

☐ Marked inability to procure financial assistance to support community living

**ADDITIONAL QUESTIONS (please circle or highlight your answer):**

1. HAS THE CLIENT BEEN FOUND NOT COMPETENT TO STAND TRIAL OR NOT CRIMINALLY RESPONSIBLE AND IS RECEIVING SERVICES RECOMMENDED BY A MARYLAND DEPARTMENT OF HEALTH EVALUATOR?

   ☐ YES ☐ NO

2. IS THE CLIENT IN A MARYLAND STATE PSYCHIATRIC FACILITY WITH A LENGTH OF STAY OF MORE THAN 3 MONTHS WHO REQUIRES RRP UPON DISCHARGE?

   ☐ YES ☐ NO

3. IS THE PRIMARY REASON FOR IMPAIRMENT DUE TO THE FOLLOWING: ORGANIC PROCESS OR SYNDROME: INTELLECTUAL DISABILITY, NEURODEVELOPMENTAL DISORDER OR NEUROCOGNITIVE DISORDER?

   ☐ YES ☐ NO

**Upon the clinician's signature below, the consumer being referred is appropriate for psychiatric rehabilitation program services provided by Partnership Development Group, Inc. This referral must be signed by a physician, nurse practitioner, or independently licensed clinician (LCSW-C or LCPC.)**

**Printed Name & Credentials: _____**

**Medical Practitioner/Therapist Signature: _____**

Agency & Address:

_____

_____