Resolution
HEALTH AND WELLNESS CENTER LLC

PSYCHIATRIC REHABILITATION PROGRAM REFERRAL

Referral Source Information

Agency/Individual Name:_____Phone #: _____

Address:_____Fax #: _____

EMAIL ADDRESS: _____

Location: □ Baltimore City: 940 Madison Ave., MD 21201 Phone: 410-275-0628

Please Indicate one of the following: On Site and Off Site: _____Off Site Only:_____On Site Only: _____

DATE OF REFERRAL: _____

Client Information

Client Name:_____Date of Birth:Gender: □ Male □ Female Parent/ Legal

Guardian Name:_____Foster Parent: □Yes □ No (if yes submit copy of court

order) Age:_**MA #:**_____**MCO:**_____**Social Security #:**_____

Ethnicity:_____Is there a current or previous substance use? □Yes □ No If yes, currently in treatment? □Yes □ No

Home Address:_____ Is the client Homeless? □Yes □ No

Best Number to Contact:_____**email address**: _____

Services Requested

❑ Mental Health Evaluation/Assessment	❑ Psychiatric Rehabilitation Services/ PRP
❑ Individual Therapy	❑ Substance Abuse Services: (circle one) IOP/ OP Counseling, DUI/DWI Groups
❑ Group Therapy	❑ Residential Housing Services
❑ Family Therapy	❑ Psychiatric Services/ Medication Evaluation

Reason for Referral/Presenting Problems (PLEASE BE SPECIFIC)

_____

_____

_____

Is the client currently on psychotropic medications? _____yes no

If yes, please list all medications_ _____

_____

- Has the client recently been discharged from an outpatient Mental Health Facility/ Hospital: □Yes □ No (If yes, have they provided a copy of the aftercare plan?) : □Yes □ No
- Has the client been arrested in the past six months? : □Yes □ No If Yes, How many times? _____
- Is the client a veteran? : □Yes □ No
- Currently enrolled in educational program? □Yes □ No **Highest Grade Completed** _____
  School Name :_____
- Currently Employed? □Yes □ No

Office Use Only

Insurance Authorization Number_____Number of Auth. Visits:_____

Dates of Authorization From:_____To: _____ Scheduled

Diagnostic Interview □ Yes □ No Date:_____Therapist: _____

Immunization Record Request □ Yes □ No Date: _____

Date Assigned/Comments:_____

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COMPLETE FOR PRP SERVICES REQUESTS ONLY:

Diagnosis: please indicate current DSM diagnoses. **(MUST HAVE AXIS I DIAGNOSIS)**
***ADULTS* MUST HAVE ONE OF THE FOLLOWING DIAGOSIS FOR PRP ELIGIBILITY**

295.90/F20.9 Schizophrenia	296.43/F31.13Bipolar I Disorder, Current or Most Recent Episode Manic, Severe
295.40/F20.81 Schizophreniform Disorder	296.44/F31.2 Bipolar I Disorder, Current or Most Recent Episode Manic Psychotic Features
295.70/F25.0 Schizoaffective Disorder, Bipolar Type	296.53/F31.4 Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe
295.70/F25.1 Schizoaffective Disorder, Depressive Type	296.54/F31.5 Bipolar I Disorder, Most Recent Episode Depressed, With Psychotic Features
298.8/F28 Other Specified Schizophrenia Spectrum and Other Psychotic Disorder	296.40/F31.9 Bipolar I Disorder, Current or Most Recent Episode Hypomanic
298.9/F29 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder	296.40/F31.9 Bipolar I Disorder, Current or Most Recent Episode Hypomanic, Unspecified
297.1/F22 Delusional Disorder	296.70/F31.9 Bipolar I Disorder, Current or Most Recent Episode Unspecified
296.33/F33.2 Major Depressive Disorder, Recurrent Episode, Severe	296.80/F31.9 Unspecified Bipolar and Related Disorder
296.34/F33.3 Major Depressive Disorder, Recurrent Episode, W/ Psychotic Features	296.89/F31.81 Bipolar II Disorder
301.22/F21 Schizotypal Personality Disorder	301.81/F60.3 Borderline Personality Disorder

Please use ICD 10 Code

Axis I: ICD CODE:

Diagnosis given by:

PLEASE COMPLETE FOR PRP AND TARGETED CASE MANAGEMENT REQUESTS

Rehabilitation Services Needed:

- ☐ Activities of Daily Living
- ☐ Anger/Temper/Conflict Resolution
- ☐ Assertiveness/Self-esteem
- ☐ Community Activity
- ☐ Family/Natural Supports
- ☐ Finances
- ☐ Home/Housing
- ☐ Self Care Skills
- ☐ Safety to Self/Others
- ☐ School Performance
- ☐ Sexual Issues
- ☐ Social Skills/Peer Interaction
- ☐ Substance Abuse Issues
- ☐ Coping Skills
- ☐ Trauma
- ☐ Medication Compliance Skills
- ☐ Vocational Skills
- ☐ Leisure Skills
- ☐ Work/Job Performance
- ☐ Legal Issues (# of arrests?)
- ☐ Money Management
- ☐ Dietary/Food Preparation
- ☐ Crisis Management Skills
- ☐ Physical Health

History of Challenges and Rehabilitation Needs:

_____

_____

_____

_____

In Current Treatment?

Treating Psychiatrist: _____ Organization_____

Address_____Phone Number: _____

Mental Health Therapist: _____ Organization_____

Address_____Phone Number: _____

Referred by:_____Date: _____

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Dates of Authorization From:_____To: _____ Scheduled

Diagnostic Interview ☐ Yes ☐ No Date:_____Therapist: _____

Immunization Record Request ☐ Yes ☐ No Date: _____

Date Assigned/Comments:_____