Referral for Psychiatric Rehabilitation Program (Child-PRP)

Referral Source Information: ☐ **Initial** ☐ **Re-Referral**

Name of person /Full name of Agency		**Date of Referral:**	
Address:			
City/ State/ Zip Code			
Mental Health Treatment Being Provided	☐Outpatient Mental Health Services ☐Inpatient Mental Health Services ☐Residential Treatment Center		

Consumer Information:

Name:			**Date of Birth:**		**Age:**
Address:		**City, State, Zip:**			
Sexual Orientation	☐**Heterosexual** ☐**Gay/Lesbian** ☐ **Bisexual** ☐**Something Else, Please Describe:** ☐ **Don't Know** ☐ **Decline**		**Language Preference:**		
Race/Ethnicity:	☐**Amer. Indian/Alaskan Native** ☐**Asian** ☐**White** ☐**Black/African American** ☐**Native American / Hawaiian or Other Pacific Islander** ☐ **Hispanic** ☐ **Non-Hispanic**				
Gender Identification	☐**Male** ☐**Female** ☐ **Transgender Male/Trans Man/(F to M)** ☐**Transgender Female/Trans Woman/(M to F)** ☐ **Genderqueer (or gender nonconforming)** ☐ **Additional Gender Category, please specify:** ☐ **Decline**				
Social Security Last 4 digits#:		**MA#**			
Phone #:		**Access to Transportation for On Site Activities:**		☐ Yes ☐ No	
Adult Contact's Name:		**Relationship:**	☐ Parent ☐ Guardian ☐ Foster Care Provider		
Address (If different):		**Does Contact Person Have Legal Custody?**		☐ Yes ☐No	
City, State, Zip:		**Phone Number:**			

History of Presenting Problems, Including social and/or psychosocial, functional behavior impairments and/or independent functioning impairments, substance, and Rationale for Referral

DSM V DIAGNOSES: (A minor must have a behavioral diagnosis and be referred by a Licensed MH Professional to be eligible for PRP.)

Primary Behavioral Diagnosis:	Diagnosis Code:		Description:				
Secondary Behavioral Diagnosis:	Diagnosis Code:		Description:				
Tertiary Behavioral Diagnosis:	Diagnosis Code:		Description:				
Social Elements Impacting Diagnoses: *(Required)* **Source of Diagnosis and Name of**	☐ None ☐ Educational ☐ Financial ☐Access to Health Care ☐Legal System/Crime ☐ Primary Support ☐ Housing ☐ Occupational ☐ Social Environment ☐ Homelessness ☐ *Other Psychosocial & Environmental ☐Unknown **Explain "Other Psychosocial & Environmental elements:*						
Diagnosing Clinician/Physician w/ credentials: *(Required)*		**Functional Assessment** *(If applicable)*		Measure Used:		Score :	

***Professional Assertion of Need for PRP Services*:**

My signature serves as my professional assertion that this individual meets the eligibility criteria outlined below and is expected to benefit from Psychiatric Rehabilitation Program (PRP) services based on the following:

(Check all that apply: Must identify at least 3)

1. ☐ The youth have a serious emotional disorder.
2. ☐ The youth's mental illness is the cause of serious dysfunction in one or more life domains (Home, school, community), the impairment as a result of the youth's mental illness results in:

   a. ☐ A clear, current threat to the individual's ability to be maintained in his/her customary setting, Or
   b. ☐ An Emerging/Pending Risk to The Safety Of The Individual Or Others, Or
   c. ☐ Other evidence of significant psychological or social impairments such as inappropriate social behavior causing serious problems with peer relationships and/or family members.

3. ☐ The individual's due to the dysfunction, is at risk for requiring a higher level of care, or is returning from a higher level of care.
4. ☐ The individual's condition requires an integrated program of rehabilitation services to develop and restore independent living skills to support the individual's recovery.
5. ☐ The person does not require a more intensive level of care and is judged to be enough behavioral control to be safe in the rehabilitation program and benefit from the rehabilitation provided.

This individual has a serious mental illness which has required the intervention of the Public Mental Health System in the last two years: Yes☐ No ☐

This individual has been seen in the ER in the last 3 months for psychiatric care: Yes ☐ No ☐

This individual has a documented crisis intervention plan completed or in progress: Yes☐ No ☐

Individual experiences at least 2 of the following:

- ☐ Inability to maintain independent employment
- ☐ Social behavior that results in interventions by the mental health system
- ☐ Inability to procure financial assistance due to cognitive disorganization
- ☐ Severe inability to establish or maintain social supports
- ☐ Need or assistance with basic living skills

Current Medications: _____

Is the individual med compliant: yes ☐ no ☐

Prescribing Physician and credentials (if applicable) _____

REASON FOR REFERRAL: *(Indicate the areas you want the PRP to address.)*

☐ **Self Care Skills:** *(Check all that apply)*	☐ personal hygiene/grooming ☐ nutrition/dietary planning	☐ dressing self ☐ following routines (bed, school)	☐ toileting ☐ self administration of meds
☐ **Semi-Independent Living Skills:** *(Check all that apply)*	☐ taking care of belongings ☐ money management	☐ maintaining living area ☐ mobility skills	☐ safety skills ☐ accessing entitlements
☐ **Interactive Skills with Others:** *(Check all that apply)*	☐ interactive skills with peers	☐ interactive skills with family	☐ interactive skills with adults
☐ **Leisure/Social Skills:**	☐ community integration	☐ participation in activities	☐ developing natural supports
☐ **Anger Management Skills:**	*Add'l info (if needed):*		
☐ **Education:**	*Add'l info (if needed):*		
☐ **Symptom Management:**	*Add'l info (if needed):*		
☐ **Community/Family Resources:**	*Add'l info (if needed):*		
☐ **Other** *Explain:*			

Mental Health Practitioner:

Name and credentials:	Date:
Signature and credentials:	Date:

Attach a "Professional Assertion of Need for PRP Services" and a copy of the current Treatment Plan.

PRP Staff use: Date Referral, Assertion of Need & Tx Plan Received_____Screening Scheduled within 5 days? Yes_____ No_____