



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	<input type="checkbox"/> Outpatient Mental Health Services <input type="checkbox"/> Inpatient Mental Health Services <input type="checkbox"/> Residential Treatment Center		

Consumer Information:

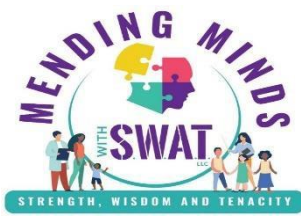
Name:		Date of Birth:		Age:	
Address:	City, State, Zip:				
Sexual Orientation	<input type="checkbox"/> Heterosexual <input type="checkbox"/> Gay/Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Something Else, Please Describe: <input type="checkbox"/> Don't Know <input type="checkbox"/>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

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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)	<input type="checkbox"/> None <input type="checkbox"/> Educational <input type="checkbox"/> Financial <input type="checkbox"/> Access to Health Care <input type="checkbox"/> Legal System/Crime <input type="checkbox"/> Primary Support <input type="checkbox"/> Housing <input type="checkbox"/> Occupational <input type="checkbox"/> Social Environment <input type="checkbox"/> Homelessness <input type="checkbox"/> *Other Psychosocial & Environmental <input type="checkbox"/> Unknown <i>*Explain "Other Psychosocial & Environmental elements":</i>			
Source of Diagnosis and Name of 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.)

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

