Referral for Psychiatric Rehabilitation Program (Child-PRP)

Referral Source Information: ☐ Initial ☐Re-Referral

Name of person and email / agency making referral:		**Date of Referral:**	
Provider's NPI			
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 ☐X 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:**			

Presenting Symptoms: (Please include History of Illness) History of Presenting Problems, Including social and/or psychosocial, Severity of Illness functional behavior impairments and/or independent functioning impairments, substance, and Rationale for Referral, Intensity of Services to treat Illness

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 Diagnosis: *(Required)*	☐ 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:*						
Source of Diagnosis: *(Required)* *Diagnosing Clinician & Credentials*		**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)

Check all that apply: 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 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

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☐

Current Medications: _____
Is the individual med compliant: ☐yes ☐no
Prescribing Physician and credentials (if applicable) _____

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

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:
Supervisor name if applicable	Date:

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

PRP Staff: Date Referral, Assertion of Need & Tx Plan Received*:* _____ Screening Scheduled within 5 days?: ____ Yes _____ No