Date of Referral: _____

**Referral Source Information**

Agency/Individual Name: _____

Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

## CONSUMER DEMOGRAPHIC INFORMATION

Consumer Name: D.O.B.: Age: Gender: ☐M ☐F

Race: Black White American Indian/Native American Asian N/A

Ethnicity: ☐Hispanic ☐Non- Hispanic Marital Status: Single Married Divorced

Employment Status: Unemployed Employed Student

Living Situation: Homeless Shelter Private Residence

Current Address:

City/State: Zip: Phone #: Alt. Contact #:

## PARENT/GUARDIAN INFORMATION *(if applicable)*

Parent/Guardian Name: (Relationship to client):

Address: City/State: Zip:

Phone#:

## CONSUMER INFORMATION, MENTAL HEALTH HISTORY & RISK FACTORS

Briefly describe Presenting Concerns/Needs (Describe symptoms, behaviors& duration):

_____

*Diagnosis(if known):* _____

Current or previous history of substance use? ☐ Yes ☐ No

Current Suicidal/Homicidal Ideation ☐Yes ☐No

History of Suicide/Homicide Attempts ☐Yes ☐No

Been discharged from psychiatric inpatient hospitalization? ☐ Yes ☐ No *(If yes, attach Aftercare plan)*

Been arrested in past 6 months? ☐Yes ☐No

Ever been accused of, or found guilty of sexual misconduct or harm to another person? ☐Yes ☐No

*If yes, please provide a brief explanation*: _____

Currently enrolled in school? ☐Yes ☐No Highest grade level completed:

*If currently in school*: Name of School: _____

*Any history of the following?*

Absenteeism? ☐Yes ☐No Suspensions? ☐Yes ☐No 504 Behavior Plan? ☐Yes ☐No IEP? ☐Yes ☐No

*Current or previous diagnosis of the following*:

Intellectual Disability Yes No Autism Spectrum Disorder Yes No

**Rendering Service Request**: Home Community School Telehealth

*Does consumer have the capability to access Telehealth options?*

**Requested Services:** Mental Health Assessment Individual Therapy Family Therapy

Group Therapy Medication Management Intensive Outpatient (IOP) Outpatient (OP)

Substance Abuse Tx Psychiatric Rehabilitation- Adult Psychiatric Rehabilitation- Youth

## COMPLETE FOR PRP REQUESTED SERVICES:

### ADULTS MUST HAVE ONE OF THE FOLLOWING DIAGNOSIS TO BE ELIGIBLE FOR PRP

| | |
|---|---|
| Schizophrenia F20.9 | Bipolar I Disorder, Current or Most Recent Episode, Manic, Severe with Psychotic Features F31.2 |
| Schizophreniform Disorder F20.81 | Bipolar I Disorder, Current or Most Recent Episode, Depressed, Severe without Psychotic Features F31.4 |
| Schizoaffective Disorder, Bipolar Type F25.0 | Bipolar I Disorder, Current or Most Recent Episode, Depressed, Severe with Psychotic Features F31.5 |
| Schizoaffective Disorder, Depressive Type F25.1 | Bipolar I Disorder, Current or Most Recent Episode, Hypomanic F31.0 |
| Other Specified Schizophrenia Spectrum and Other Psychotic Disorder F28 | Bipolar I Disorder, Current or Most Recent Episode, Hypomanic, Unspecified F31.9 |
| Unspecified Schizophrenia Spectrum and Other Psychotic Disorder F29 | Bipolar I Disorder, Current or Most Recent Episode, Unspecified F31.9 |
| Delusional Disorder F22 | Bipolar II Disorder F31.9 |
| Major Depressive Disorder, Recurrent Episode, Severe without Psychotic Features F33.2 | Schizotypal Personality Disorder F21 |
| Major Depressive Disorder, Recurrent Episode, Severe with Psychotic Features F33.3 | Borderline Personality Disorder F60.3 |
| Bipolar I Disorder, Current or Most Recent Episode, Manic, Severe without Psychotic Features F31.13 | |

Axis 1 (ICD-10):_____
Therapist Name: _____ Credentials: _____

**Requested Rehabilitation Services:**
__Activities of daily Living __Vocational skills __Anger Management __Finances
__Conflict Resolution __Medication Compliance __Substance Abuse Interventions
__Self Esteem/ Assertiveness __Legal Issues __Social Skills __Coping Strategies
__Trauma __Self Care __ Physical Health __Money Management __Housing
__Academic Support __Structured Leisure
PRP Needs Identified:

_____

_____

_____

Client is in current treatment? __Y __N
If Yes; Therapist Name: _____Phone: _____
Psychaitrist Name: _____ Phone: _____

**Office Use Only:**
Insurance Authorization Number: _____Number of Authorized Units
Dates of Authorization From_____To _____
Schedule Consents __Y __N Date: _____Optional: __emailed Date received _____
Scheduled Bio psycho social interview __Y__N Date: _____
Immunization record requested __Y__N Date:_____|Uploaded to EHR __Y __N