Psychiatric Rehabilitation Program Referral Form

Date: _____ **Referring Agency:** _____

Therapist: _____ **Licensure Level:** _____

Phone: _____ **Fax:** _____ **Email Address:** _____

Consumer Name: _____ **Gender:** _____ **DOB**: _____

Medical Assistance #: _____

Beacon Health Options Member ID#: _____

SSN: _____ **Race:** _____

Address: _____ **Zip:** _____ **Phone:** _____

Legal Guardian: _____ **Relationship (to minor):** _____

Legal Guardian Address (if different from above): _____

School: _____ **Grade:** _____

Primary Care Physician: _____ **Address:** _____

Phone: _____ **Fax:** _____

Rehabilitation Services Needed (*please check all that apply)*

- ☐ **Activities of Daily Living**
- ☐ **Anger/Temper/Conflict Resolution**
- ☐ **Assertiveness/Self Esteem**
- ☐ **Community Activity**
- ☐ **Family/Natural Supports**
- ☐ **Self Care Skills**
- ☐ **Safety to Self/Others**
- ☐ **Substance Abuse Issues**
- ☐ **Legal Issues (# of arrests_____)**
- ☐ **Coping Skills**
- ☐ **Trauma**
- ☐ **Medication Compliance Skills**
- ☐ **Crisis Management Skills**
- ☐ **Physical Health**
- ☐ **Sexual Issues**
- ☐ **School Performance**
- ☐ **Social Skills /Peer Interaction**

History of Problems ***(please include school suspensions, hospitalizations, runaways within the last 90 days or physical assault):***

_____

_____

638 N. Gilmor Street Baltimore, MD 21217
(410) 462-ABOV (2268)
(410) 523-1434 (f)
info@aiahealth.org www.aiahealth.org

Current Treatment

1. Therapist Name and Phone: _____

2. Psychiatrist Name and Phone: _____

Behavioral Diagnosis (*Please use the current DSM V diagnoses)*

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Diagnosis given by: _____ Date: _____

Primary Medical Diagnoses *(if there is not a medical diagnosis, please state "none")*

_____

Social Elements Impacting Diagnosis
Check all that apply:

- ☐ **None**
- ☐ **Educational Problems**
- ☐ **Financial Problems**
- ☐ **Problems with access to health care services**
- ☐ **Problems related to interaction w/legal system/crime**
- ☐ **Problems with Primary support group**
- ☐ **Housing problems (not homelessness)**
- ☐ **Occupational Problems**
- ☐ **Psychosocial and environmental problems - Please explain: _____**
- ☐ **Problems related to the social environment**
- ☐ **Medical disabilities that impact diagnosis or must be accompanied for in treatment**
- ☐ **Homelessness**
- ☐ **Unknown**

Is client on medication? __ Yes __ No (*please list medication and dosage*)

_____

Collaboration Agreement

I, _____ (*Therapist Name and Title*), agree to participate in team treatment planning sessions/initial session within two weeks of receipt of the referral and quarterly sessions in person or by phone.

Therapist Signature: _____Date: _____

Please attach Copies of the following:

1. Current Psychosocial, Psychiatric or Psychological Evaluation
2. Current Court Orders
3. Current Therapist Treatment Plan

For AIA Staff Only

Date Referral Received: _____
Received By: _____
Beacon Health Options Authorization Number: _____Date: _____
AIA Intake Staff Signature: _____ Date: _____

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