Psychiatric Rehabilitation Program Referral Form

You must be one of the following Licensure to complete this referral. If you are not one of the following Licensure, you may complete the referral and have your Supervising Clinician sign the referral.
MD, PhD, LMSW, LCSW-C, LCPC, LCMFT, APRN-PMH/CRNP-PMH, LCADC or LCPAT

Date:______________ **Referring Agency:** ____

Therapist:____ **Licensure Level:**______________

Phone:____________________ **Fax:**___________________ **Email**____________________________

Please complete this referral in its entirety. Thank You!

Consumer Name:_____________________ **Gender:** _________________ **DOB:**___________________

Medical Assistance #: ____

SSN: ______________________ **Race:**_____________________**Phone Number:** ___________________

Address:_______________________________**City:** _________________ **State:** ______ **Zip:** _________

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

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

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

____

____

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")***

____

How often is the client in treatment per month? ____________________________

How long has the client been in outpatient therapy? ____________________________

How many Psychiatric ER visits in the last 90 days? ____________________________

Social Elements Impacting Diagnosis

Check all that apply:

- ☐ **None**
- ☐ **Educational Problems**
- ☐ **Financial Problems**
- ☐ **Problems with access to health care services**
- ☐ **Homelessness**
- ☐ **Problems related to interaction w/legal system/crime**
- ☐ **Problems with Primary support group**
- ☐ **Housing problems (not homelessness)**
- ☐ **Occupational Problems**

- ☐ **Problems related to the social environment**
- ☐ **Medical disabilities that impact diagnosis or must be accompanied for in treatment**
- ☐ **Psychosocial and environmental problems - Please explain:** ____________________________

____

- ☐ **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:________________________

Supervising Clinician's Signature/Licensure Level: ____

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: ______________________________________

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