Advantage Psychiatric Services, LLC
Child & Adolescent Rehabilitation Program
Referral Form

Millersville: Fax Referral to 410-846-5079
White Marsh: Fax Referral to 410-780-7178 Woodlawn: Fax Referral to 443-551-3590

DEMOGRAPHIC INFORMATION:		
Client Name:		
Parent/Legal Guardian Name:		
Address:		
Phone Number (best and alternate):		
DOB:	SS#:	
Medical Assistance # (if uninsured, note if an application is pending):		
Gender:	Race(s):	Ethnicity:

This form must be filled out in its entirety in order to allow for medical necessity and authorization for services.

BEHAVIORAL DIAGNOSES DESCRIPTION:
Primary Diagnosis:
Additional Diagnosis:

MEDICAL DIAGNOSES:	
Diagnosis Code #1:	Diagnosis #2:
Diagnosis Code #3:	Diagnosis #4:

SOCIAL ELEMENTS IMPACTING DIAGNOSIS:

☐ None ☐ Educational ☐ Financial ☐ Problems with Access to Healthcare Services
☐ Problems Related to Interactions with Legal System/Crime ☐ Primary Support Group
☐ Housing Problems (Not Homelessness) ☐ Occupational Problems
☐ Problems Related to the Social Environment ☐ Homeless ☐ Unknown
☐ Other Psychosocial and Environmental Problems
☐ Please Specify: _____

FUNCTIONAL ASSESSMENT:	
Assessment Measure:	Score:
Diagnosis Source:	

Admission Criteria – Verify that all of the following admission criteria are met.

a. Client has a PMHS specialty mental health diagnosis and the individual's impairment(s) and functional behavior is expected to improve with these services.
b. The minor's mental illness is the cause of serious dysfunction in one or more life domains (home, school, community)
c. The impairment as a result of the youth's mental illness results in:
   A clear, current threat to the Individual's ability to be maintained in his/her customary setting, or
   An emerging/pending risk to the safety of the Individual and others, or
   Other evidence of significant psychological or social impairments such as inappropriate social
   Behavior causing serious problems with peer relationships and/or family members.
d. The Individual, due to the dysfunction, is at risk for requiring a higher level of care, or is returning from a higher level of care.
e. The Individual's condition requires an integrated program of rehabilitation services to develop and restore independent living skills to support the Individual's recovery.
f. The Individual does not require a more intensive level of care and is judged to be in enough behavioral control to be safe in the rehabilitation program and benefit from the rehabilitation provided.
g. A documented crisis response plan for the Individual is in progress or completed.
h. An Individual Rehabilitation Plan (IRP) is in progress or completed.
i. PRP services will be rendered by staff that is supervised by a licensed mental health professional.

And either:

There is clinical evidence that the current intensity of outpatient treatment will not be sufficient to reduce the youth's symptoms and functional behavioral impairment resulting from the mental illness and restore him/her to an appropriate functional level, or prevent clinical deterioration, or avert the need to initiate a more intensive level of care due to current risk to the Individual or others; or

For Individual transitioning from an inpatient, day hospital or residential treatment setting to a community setting there is clinical evidence that PRP services will be necessary to prevent clinical deterioration and support successful transition back to the community, or avert the need to initiate or continue a more intensive level of care.

MEDICATIONS (If Known):		
Medication Name	Dosage/Frequency	Prescribing Physician

Presenting Symptoms: Please include hx of SI and HI and/or judicial involvement including Child Protective Services (CPS).

Reason for Referral: What types of goals should be the focus of intervention:

Attach the following: Current Med Sheet and ITP.

COMMENTS (Additional Needs/Areas of Concern):

Referring name/credentials (if applicable): _____

Email address/phone: _____

Signature and Credentials: _____ **Date:** _____