Advantage Psychiatric Services, LLC

Adult Targeted Case Management Referral Form

Fax Referral to 410-392-3417

DEMOGRAPHIC INFORMATION:		
Name:		
Address:		
Phone Number (best and alternate):		
DOB:	SS#:	
Medical Assistance # (if uninsured, note if an application is pending):		
Gender:	Race(s):	Ethnicity:
Marital Status:	Veteran? ☐ Yes / ☐ No	
Highest Level of Education:	Employment Status:	

DIAGNOSTIC INFORMATION:	
Behavioral Health Diagnosis:	ICD 10 Code:
Medical Diagnosis:	ICD 10 Code:
Assessment Measure:	Score:

SOCIAL ELEMENTS IMPACTING DIAGNOSIS (CHECK ALL THAT APPLY):

☐ 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
☐ Other psychosocial and environmental problems ☐ Problems related to the social environment
☐ Homeless ☐ Unknown

TCM Director: Becky Smith, CPRP
306 W. Pulaski Hwy.
Elkton, MD 21921
{P} 410-686-3629
{C} 443-800-5607
{F} 410-392-3417
www.advantagepsyc.com

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

REASON(S) FOR REFERRAL:

☐ Have a serious/persistent mental health disorder

At Risk For:

☐ Inpatient Psychiatric Treatment
☐ Homelessness
☐ Incarceration or has been recently released from incarceration
☐ Does not have insurance
☐ Identified by the ASO or the CSA as a High Inpatient User (HIU) or other high priority population

LEVEL OF CARE CRITERIA - PLEASE INDICATE WHICH OF THE FOLLOWING APPLY:

(Number of visits per month will be determined by number of criteria the individual meets)

☐ Participant is not linked to mental health and medical services;

☐ Participant lacks basic supports for shelter, food, and income;

☐ Participant is transitioning from one level of care to another level of care; or

☐ Participant needs case management services to maintain community- based treatment and services.

COMMENTS:

Referring name/credentials (if applicable): _____

Email address/phone: _____

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