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

Fax Referral to 410-780-7178

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:
Diagnosis Code #2:
Diagnosis Code #3:

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 at least one of the following admission criteria is met:

1. In the past three months, how many ER visits has the youth had for psychiatric care?

2. What evidence exists to show that the current intensity of outpatient treatment for this individual is insufficient to reduce the youth's symptoms and functional behavioral impairments resulting from mental illness?

3. List attempts and outcomes of any efforts to serve this individual through less formal means such as peer supports, or family:

Functional Impairments and at least one must be yes with explanation and within the past 3 months:

A clear, current threat to the youth's ability to be maintained in their customary setting?

An emerging risk to the safety of the youth or others?

Significant psychological or social impairments causing serious problems with peer relationships and/or family members?

What evidence exists to show that the current intensity of outpatient treatment for this individual is insufficient to reduce the youth's symptoms and functional behavioral impairments resulting from mental illness?

Has medication been considered for this youth? (If medication is not listed)

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):

Printed Referring Clinician's name/credentials: ______________________

Email Address: ______________________ **Phone:** ______________________

Signature and Credentials: ______________________ **Date:** ______________________

Printed Clinical Supervisor of LMSW or LGPC name/credentials: ______________________

Email Address: ______________________ **Phone:** ______________________