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

Fax Referral to 410-780-7178 ☐ New Referral ☐ Re-Referral

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:
Marital Status:		
Highest Level of Education:	Employment Status:	
Primary Language:	Secondary Language:	

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

BEHAVIORAL DIAGNOSES DESCRIPTION: (Please include Code#)
Diagnosis Code #1:
Diagnosis Code #2:

MEDICAL DIAGNOSES DESCRIPTION: (Please include Code#)
Diagnosis Code #1:
Diagnosis Code #2:

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:

CLINICAL INFORMATION:	
Diagnosed By: (Name of Clinician, Credentials, Agency)	
The youth has been engaged in active, documented outpatient treatment in total for?	Current frequency of treatment:
How many ER visits has the youth had for psychiatric care in the past 3 months?	Youth transitioning from an inpatient day hospital or residential treatment setting to a community setting? ☐ Yes ☐ No If Yes, what level of care transitioning from and to:

FUNCTIONAL CRITERIA:

1. **Functional Impairments: (At least one of the following below admission criteria must be met within the last 3 months)**
   a. A clear, current threat to the youth's ability to be maintained in their customary setting? ☐ Yes ☐ No
   If yes, please provide detailed information/evidence.

   b. An emerging risk to the safety of the youth or others? ☐ Yes ☐ No
   If yes, please provide detailed information/evidence.

   c. Significant psychological or social impairments causing serious problems with peer relationships and/or family members. ☐ Yes ☐ No
   If yes, please provide detailed information/evidence.

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?**

Has medication been considered for this youth?

☐ Not Considered ☐ Considered and Ruled Out ☐ Initiated and Withdrawn ☐ Ongoing ☐ Other (Explain):

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

Please attach a Medication Log and an ITP.

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:

Please check all that apply:

Self Care Skills: ☐ hygiene/grooming ☐ dressing self ☐ nutrition/dietary planning ☐ toileting
☐ following routines (bed, school) ☐ self administration of medications
Semi-Independent Living Skills: ☐ taking care of belongings ☐ maintaining living area ☐ safety skills
☐ mobility skills ☐ money management ☐ accessing entitlements
Interactive Skills with Others: ☐ with peers ☐ with family ☐ with adults/authority
Leisure/Social Skills: ☐ community integration ☐ participation in activities ☐ developing natural supports
Behavior Management Skills: ☐ anger ☐ coping ☐ social
Education: Explain:
Symptom Management:
Community/Family Resources:
Other (Explain):

COMMENTS (Additional Needs/Areas of Concern):

If LMSW, LGPC or intern, please include your Clinical Supervisor's name and credentials:

Print Referring Clinician's Name/Credentials: _____

Email Address: _____ **Phone:** _____

Signature and Credentials: _____ **5I·úŜ** _____

***Print Clinical Supervisor's Name/Credentials if above is *LMSW or LGPC* :** _____

Email Address: _____ **Phone:** _____