Advantage Psychiatric Services, LLC
Adult Psychiatric Rehabilitation Program (PRP) Referral Form

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

DEMOGRAPHIC INFORMATION:		
Client 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:	
Primary Language:	Secondary Language:	

Preferred Type of Service: ☐ **Onsite (Day Program)** ☐ **Offsite (In Home)**

*If uninsured, Medicare, QMB, or SLMB recipient, additional criteria must be met in order to qualify for services (stepdown from a state hospital, discharge from an acute psychiatric hospitalization in the last 6 months, court ordered in last 6 months or discharged from a RRP within last 6 months.)

BEHAVIORAL DIAGNOSIS

Primary Code/Description: *(Note that eligibility for PRP services is restricted to the following below diagnoses (updated to reflect DSM-5))*

☐	**Category A/ F20.0**	**Paranoid Schizophrenia**
☐	**Category A/ F20.1**	**Disorganized Schizophrenia**
☐	**Category A/ F20.2**	**Catatonic Schizophrenia**
☐	**Category A/ F20.3**	**Undifferentiated Schizophrenia**
☐	**Category A/ F20.5**	**Residual Schizophrenia**
☐	**Category A/ F20.81**	**Schizophreniform Disorder**
☐	**Category A/ F20.89**	**Other Schizophrenia**
☐	**Category A/ F20.9**	**Schizophrenia, unspecified**
☐	**Category A/ F25.0**	**Schizoaffective Disorder, Bipolar Type**
☐	**Category A/ F25.1**	**Schizoaffective Disorder, Depressive Type**
☐	**Category A/ F25.8**	**Other Schizoaffective Disorder**
☐	**Category A/ F25.9**	**Schizoaffective Disorder, unspecified**
☐	**Category A/ F22.0**	**Delusional Disorders**
☐	**Category A/ F28.0**	**Other Psychotic Disorder**
☐	**Category A/ F29.0**	**Unspecified Psychosis**
☐	**Category A/ F31.2**	**Bipolar I Disorder, current episode manic, severe with psychotic features**
☐	**Category A/ F31.5**	**Bipolar I Disorder, current episode depressed, severe with psychotic features**
☐	**Category A/ F31.64**	**Bipolar I Disorder, current episode mixed, severe with psychotic features**
☐	**Category A/ F33.3**	**Major Depressive Disorder, recurrent, severe with psychotic features**
☐	**Category B/ F31.0**	**Bipolar I Disorder, current episode hypomanic**
☐	**Category B/ F31.13**	**Bipolar I Disorder, current episode manic, severe without psychotic features**
☐	**Category B/ F31.4**	**Bipolar I Disorder, current episode depressed, severe without psychotic features**
☐	**Category B/ F31.63**	**Bipolar I Disorder, current episode mixed, severe without psychotic features**
☐	**Category B/ F31.81**	**Bipolar II Disorder**
☐	**Category B/ F31.9**	**Bipolar Disorder, unspecified**
☐	**Category B/ F33.2**	**Major Depressive Disorder, recurrent, severe without psychotic features**
☐	**Category B/ F60.3**	**Borderline Personality Disorder**

ADDITIONAL BEHAVIORAL DIAGNOSES DESCRIPTIONS: (Please use code#)	
Diagnosis Code #1:	Diagnosis Code #2:

MEDICAL DIAGNOSES DESCRIPTIONS: (Please use 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
☐ Homeless ☐ Problems Related to the Social Environment ☐ Unknown
☐ Other Psychosocial and Environmental Problems- Please specify _____

FUNCTIONAL ASSESSMENT:	
Assessment Measure:	Score:

CLINICAL INFORMATION:	
Diagnosed By: (Name of clinician, credentials, agency)	
Duration of current episode of treatment provided.	Current frequency of treatment:
Psychiatric hospitalization stay in the last 6 months? ☐ Yes ☐ No	Please include dates of recent hospitalization stay(s):

FUNCTIONAL CRITERIA

Functional Impairments (Individual MUST experience at least 3 of the below and it must relate back to their primary mental health diagnosis): Please check any appropriate functional impairment AND the additional questions below it.

☐ **Inability to establish or maintain competitive employment:**

Examples of this impairment:

Impact to client:

How it relates to their mental health:

☐ **Inability to perform instrumental activities of daily living (shopping, meal prep, med management, transportation and money management):**

Examples of this impairment:

Impact to client:

How it relates to their mental health:

☐ **Inability to establish and/or maintain a personal support system:**

Examples of this impairment:

Impact to client:

How it relates to their mental health:

☐ **Deficiencies of concentration, persistence or pace leading to failure to complete tasks**:

Examples of this impairment:

Impact to client:

How it relates to their mental health:

☐ **Inability to perform or maintain self-care (hygiene, grooming, nutrition, medical care, safety)**:

Examples of this impairment:

Impact to client:

How it relates to their mental health:

☐ **Deficiencies in self-direction, shown by inability to plan, initiate, organize and carry out goal directed activities:**

Examples of this impairment:

Impact to client:

How it relates to their mental health:

☐ **Inability to procure financial assistance to support community living:**

Examples of this impairment:

Impact to client:

How it relates to their mental health:

ALTERNATIVE SERVICE AND TRANSITION CONSIDERATIONS

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

REASON(S) FOR REFERRAL:

☐ Personal Hygiene ☐ Grooming ☐ Nutrition ☐ Dietary Planning ☐ Food Preparation

☐ Self-Administration of Medication ☐ Community Integration Activities ☐ Developing Natural Supports

☐ Developing Linkages with and Supporting the Individual's Participation in Community Activities.

☐ Skills Necessary for Housing Stability ☐ Community Awareness

☐ Mobility and Transportation Skills ☐ Money Management

☐ Accessing Available Entitlements and Resources ☐ Supporting the Individual to obtain and retain employment

☐ Health Promotion and Training ☐ Individual Wellness Self-Management and Recovery

MEDICATIONS (If Known):

Medication Name	Dosage/Frequency	Prescribing Physician

Presenting Symptoms: Please include history of SI and HI.

Please attach a Medication Log and an ITP.

COMMENTS (Additional Needs/Areas of Concern):

Therapist Information:

(If LMSW or LGPC, please include your clinical supervisor's name and credentials further below)

Print Referring Clinician's Name/Credentials: _____

Email Address: _____ Phone: _____

Referring Clinician's Signature and Credentials: _____
(Electronic Signature)

Date: _____

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

Supervisor's Email Address: _____ Phone: _____

****An LMSW must be signed off by an LCSW-C.**
****An LGPC must be signed off by an LCPC.**