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: ____________________) ____________________
(Electronic Signature)

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

Email Address: ____________________ **Phone:** ____________________

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