Psychiatric Rehabilation Program (PRP) Referral Form

Identifying Information:

Client's Name: _____ Age: _____ Transition Age Youth? Y/N D.O.B. _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Number: ( ) _____ Home/Other: ( ) _____

Social Security Number: _____

Race: _____ Ethnicity: _____ Marital Status: _____ Gender: _____ Current Level of Education: _____

Insurance Type: _____ Medicaid #: _____ Authorized: YES NO

Does the Parent/Guardian have legal custody of the minor? YES NO N/A

If they are an adult, do they have a legal guardian? YES NO N/A

If parent does not have custody, please provide custodial information:

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Please note: Services cannot begin unless proof of custody is provided.

MEDICAL NECESSITY CRITERIA
Psychiatric Rehabilitation Program Services (PRP)

_____ _____

Name of Client Referring Clinician and Credential

_____ _____

Diagnosis: Please use ICD 10 codes Date

Diagnosed by:

Diagnosis: please indicate current DSM diagnoses. (MUST HAVE AXIS I DIAGNOSIS)
ADULTS MUST HAVE ONE OF THE FOLLOWING DIAGOSIS FOR PRP ELIGIBILITY

295.90/F20.9 Schizophrenia
295.40/F20.81 Schizophreniform Disorder
295.70/F25.0 Schizoaffective Disorder, Bipolar Type
295.70/F25.1 Schizoaffective Disorder, Depressive Type
298.8/F28 Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
298.9/F29 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
297.1/F22 Delusional Disorder
296.33/F33.2 Major Depressive Disorder, Recurrent Episode, Severe
296.34/F33.3 Major Depressive Disorder, Recurrent Episode, W/ Psychotic Features
301.22/F21 Schizotypal Personality Disorder
296.43/F31.13Bipolar I Disorder, Current or Most Recent Episode Manic, Severe
296.44/F31.2 Bipolar I Disorder, Current or Most Recent Episode Manic Psychotic Features
296.53/F31.4 Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe
296.54/F31.5 Bipolar I Disorder, Most Recent Episode Depressed, With Psychotic Features
296.40/F31.9 Bipolar I Disorder, Current or Most Recent Episode Hypomanic
296.40/F31.9 Bipolar I Disorder, Current or Most Recent Episode Hypomanic, Unspecified
296.70/F31.9 Bipolar I Disorder, Current or Most Recent Episode Unspecified
296.80/F31.9 Unspecified Bipolar and Related Disorder
296.89/F31.81 Bipolar II Disorder
301.81/F60.3 Borderline Personality Disorder

Reason for Referral/Rehabilitation Needs (PLEASE BE SPECIFIC)

_____

_____

_____

_____

_____

Is the client currently on psychotropic medications? □Yes □ No

If yes, please list all medications_____

□ Has the client recently been discharged from an outpatient Mental Health Facility/ Hospital: □Yes □ No
(If yes, have they provided a copy of the aftercare plan?) : □Yes □ No
□ Has the client been arrested in the past six months? : □Yes □ No If Yes, How many times? _____
□ Is the client a veteran? : □Yes □ No
□ Currently enrolled in educational program? □Yes □ No Highest Grade Completed _____
School Name :_____
□ Employment Status: _____ Employer _____
Preferred day/time of appointment:

_____

Other Preferences:

_____

Suicide Risk: ___ Danger to Self or Others: ___ Urgent/Critical Medical Condition: ___ Immediate Threat(s): _____ Past Psychiatric Admission(s): □Yes □ No
Previous Outpatient Treatment: □Yes □ No
Current Outpatient Provider: _____ Phone: _____
Treating Mental Health Therapist_____ Phone: _____
Treating Psychiatrist _____ Phone: _____

PLEASE COMPLETE FOR PRP AND TARGETED CASE MANAGEMENT REQUESTS

	Activities of Daily Living		Anger/Temper/Conflict Resolution
	Assertiveness/Self Esteem		Community Activity
	Family/ Natural Supports		Finances
	Home/Housing		Self Care Skills
	Safety to Self/Others		School Performance
	Sexual Issues		Social Skills/Peer Interaction
	Substance Abuse Issues		Coping Skills
	Trauma		Medication Compliance Skills
	Vocational Skills		Leisure Skills
	Work/Job Performance		Legal Issues (# of Arrests)
	Money Management		Dietary/Food Preparation
	Crisis Management Skills		Physical Health

Referral Source Printed Name & Institution (IF APPLICABLE)

_____

Referral Source Signature: _____ Date: _____