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:
Diagnosis Code #3:

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

☐ Housing Problems (Not Homelessness) ☐ Occupational Problems

☐ Problems Related to the Social Environment ☐ Homeless ☐ Unknown

☐ Other Psychosocial and Environmental Problems - Please Specify:

Assessment Measure:	Score:

FUNCTIONAL ASSESSMENT:

CLINICAL INFORMATION

Diagnosed By: (Name of Clinician, Credentials, Agency)	
How long has this youth been receiving mental health therapy (if applicable, even before you/your agency)?	Current frequency of treatment: ☐ 1x/weekly ☐ 1x/biweekly ☐ 1x/monthly ☐ Other: (write below)
How many ER visits has the youth had for psychiatric care in the past 3 months? ☐ None ☐ One ☐ Two ☐ Three or more Dates of ER visits in last 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: (<u>At least one</u> 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 as to why it is a current threat and how it relates to their primary diagnosis as listed on page 1 under the first behavioral diagnosis.

   b. An emerging risk to the safety of the youth or others? ☐ Yes ☐ No
   If yes, please provide detailed information/evidence as to why they are an emerging risk and how it relates to their primary diagnosis as listed on page 1 under the first behavioral diagnosis.

   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 as to what the impairment are with family/peers and how it relates to their primary diagnosis as listed on page 1 under the first behavioral diagnosis.

Has medication been considered for this youth?

☐ Not Considered ☐ Considered & Ruled Out ☐ Initiated and Withdrawn ☐ Ongoing ☐ Other (Explain below):

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 CPS.

REASON FOR THE REFERRAL: WHAT TYPES OF GOALS SHOULD BE THE FOCUS OF INTERVENTION?

☐ Self-Care Skills: ☐ Hygiene/grooming ☐ Dressing self ☐ Nutrition/dietary planning ☐ Toileting
☐ Following routines (home, 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 (Explain):
☐ Community/Family Resources (Explain):
☐ Other (Explain):

ADDITIONAL COMMENTS FOR NEEDS/CONCERNS

Therapist Information:

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

Print Referring Clinician's Name/Credentials: _____

Email Address: _____ **Phone:** _____

Referring Clinician's Signature and Credentials: _____

Date: _____ NPI:_____

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.**