# 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): |
| 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 in order to quality 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 #2: | Diagnosis Code #3: |

| MEDICAL DIAGNOSES DESCRIPTIONS: (Please use code#) | |
|---|---|
| Diagnosis Code #1: | Diagnosis Code #2: |

**Is the primary reason for the participant's impairment due to an organic process or syndrome, intellectual disability, a neurodevelopmental disorder or neurocognitive disorder (e.g. dementia, autism, stroke, brain injury)? If the answer is YES, participant is NOT eligible for services.**

| MEDICATIONS ONLY RELATED TO BEHAVIORAL HEALTH DX (If Known): | | |
|---|---|---|
| **Medication Name (required)** | **Dosage (required)** | **Frequency (required)** |
| | | |
| | | |
| | | |
| | | |
| | | |
| Please attach a Medication Log and an ITP. | | |

**If client is not on medication, explain why:**

**Is the participant in ongoing, active treatment with the referring provider?** ☐ Yes ☐ No
Participant must have at least 4 visits with referring therapist in order to submit a PRP referral. Those 4 visits must be within 60 days to qualify for PRP.

| CLINICAL INFORMATION: | |
|---|---|
| **Diagnosed By**: (clinician's name, credentials, agency required) | **Legal Involvement in last 6 months**: ☐ Yes ☐ No |
| **How long has participant been seeking mental health services? Please include any time prior to you and/or your agency if applicable.** ☐ less than 1 month ☐ 2-3 months ☐ 4-6 months ☐ 7-12 months ☐ more than 12 months | **How often are they seen**: ☐ 1x/weekly ☐ 2x/weekly ☐ 1x/2 weeks ☐ Other ☐ Also being seen in psychiatry/NP/med management monthly **(If participant is only seen 1x monthly in therapy and not at all in psychiatry, med management or by an NP, they will not qualify)** |
| **Psychiatric hospitalization stay in the last 6 months?** ☐ Yes ☐ No | **Please include dates of recent hospitalization stay(s):** |

**Why is ongoing outpatient treatment with you not sufficient to address concerns?**

**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 CRITERIA

**FUNCTIONAL IMPAIRMENTS-** Individual MUST experience at least 3 from functional impairments listed below and requires evidence written in to prove need of continued PRP services. No previous referrals to be used again please or Optum will automatically decline.

**A. Inability to establish or maintain competitive employment:**

1) Describe 2 symptoms of the Priority Population Diagnosis that affect the participant's functioning in employment.

2) Provide specific concrete examples of THIS participant's impaired function to employment.

**B. Inability to perform instrumental activities of daily living like shopping, meal prep, med management, laundry, basic housekeeping, transportation and money management:**

1) Describe 2 symptoms of the Priority Population Diagnosis that affect the participant's functioning in ADLs.

2) Provide specific concrete examples of THIS participant's impaired function to ADLs.

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

1) Describe 2 symptoms of the Priority Population Diagnosis that affect the participant's functioning in personal support systems.

2) Provide specific concrete examples of THIS participant's impaired function in establishing/maintaining support.

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

1) Describe 2 symptoms of the Priority Population Diagnosis that affect the participant's functioning in completing tasks.

2) Provide specific concrete examples of THIS participant's impaired function in completing tasks.

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

1) Describe 2 symptoms of the Priority Population Diagnosis that affect the participant's functioning in self-care.

2) Provide specific concrete examples of THIS participant's impaired function in completing tasks.

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

1) Describe 2 symptoms of the Priority Population Diagnosis that affect the participant's functioning in goal directed activities:

2) Provide specific concrete examples of THIS participant's impaired function in self-care.

G. **Inability to obtain financial assistance to support community living:**

1) Describe 2 symptoms of the Priority Population Diagnosis that affect the participant's functioning to support community living.

2) Provide specific concrete examples of THIS participant's impaired function in completing goal directed activities.

**REASON(S) FOR REFERRAL:**

- ☐ Personal Hygiene ☐ Grooming ☐ Nutrition ☐ Dietary Planning ☐ Food Preparation
- ☐ Self-Administration of Medication ☐ Community Integration Activities ☐ Developing Natural Supports
- ☐ Developing Linkages 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

**History of SI and HI.**

**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 Legal Name/Credentials:** _____
**(Please list full name as it appears with the licensing board)**

**Email Address:** _____ **Phone:** _____

**Referring Clinician's Signature and Credentials:** _____
**(Please list full name as it appears with the licensing board)**

**Therapist's NPI:** _____ **Date of Referral:** _____

**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.**