



Advantage Psychiatric Services, LLC

Child & Adolescent Rehabilitation Program

Referral Form

Fax Referral to 410-780-7178

New Referral

Re-Referral

DEMOGRAPHIC INFORMATION: (ages 5-17)		
Client Name:		
Parent/Legal Guardian Name:	Relationship to Client:	
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	Problems with Access to Healthcare Services
Educational	Occupational Problems
Financial	Homeless
Housing Problems (Not Homelessness)	Unknown
Problems Related to the Social Environment	
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: (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?
- b. An emerging risk to the safety of the youth or others?
- c. Significant psychological or social impairments causing serious problems with peer relationships and/or family members.

Has medication been considered for this youth?

Not Considered Considered and Ruled Out Initiated and Withdrawn Ongoing Other (Explain below):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

Clinician Information: (Clinician listed MUST be enrolled in Medicaid)

Print Referring Clinician’s Name and Credentials: _____

Email Address: _____ **Phone:** _____

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

Enrolled NPI: _____ **Date of Referral:** _____

Advantage Psychiatric Services
Phone: 410-686-3629
Fax: 410-780-7178
www.advantagepsyc.com