Child & Adolescent Rehabilitation Program (PRP)
Referral Form

☐ **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:

Current Living Arrangement (check appropriate boxes below)	
☐Parent, guardian or relative legally responsible for care	☐Independently or w/individuals not legally responsible for care
☐Foster home (DHR or CPA)	☐Crisis residential
☐Residential care (i.e. group home)	☐Homeless/shelter
☐RTC or Inpatient acute psychiatric	☐Correctional/Detention facility
☐Other (specify):	

BEHAVIORAL DIAGNOSES DESCRIPTION: (Please include Code#)
Diagnosis Code #1:
Diagnosis Code #2:
MEDICAL DIAGNOSES DESCRIPTION: (Please include Code#)
Diagnosis Code #1:
Diagnosis Code #2:

Medications	**Dosage**	**Frequency**

Presenting Symptoms: Please include hx of SI and HI and/or judicial involvement, including CPS.

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? ☐ None ☐One ☐Two ☐Three or more Dates of ER visits in the 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? ☐ 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 impairments are with family/peers and how it relates to their primary diagnosis as listed on page 1 under the first behavioral diagnosis.

2. What evidence exists to show that current outpatient therapy is not enough to keep this individual out of PRP services? Why isn't therapy sufficient to reduce youth's symptoms and functional behavioral impairments resulting from mental health?

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 or LGPC, YOU MUST include your clinical supervisor's name and credentials please further below) along with the referring providers National Provider Identifier Number)

Print Referring Clinician's Name and Credentials: _____

Print Clinician's Agency: _____

Email Address: _____ **Phone:** _____

Referring Clinician's Signature and Credentials:_____

(Electronic Signature)

Referring Clinician/Provider's NPI#: _____

Date: _____

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

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

Supervisor's Signature: _____**(Electronic Signature)**

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