PSYCHIATRIC REHABILITATION SERVICES
PROGRAM REFERRAL FORM

REFERRAL SOURCE INFORMATION

DATE OF REFERRAL:			
Referring Agency/Address:			
Referring Worker (title and credentials):		**Phone**	
Email Address:		**Fax Number:**	

CLIENT INFORMATION

Consumer Name				**Gender**		**Marital Status**	
SSN:		**DOB:**		**AGE**		**RACE:**	
Medical Assistance #				**Legal Guardian:**			
Full Address:							
Phone:				**Alternate Phone:**			
Primary Care Physician:				**Phone Number:**			
Employer/School				**Grade**			
Address				**Phone**			

Rehabilitation Services Needed:

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

History of Problems: i.e. (school suspensions, hospitalizations, runaways within the last 30 days, physical assault)

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Current Treatment

1. **Therapist Name and Phone Number:** ____
2. **Psychiatrist Name and Phone Number:** ____

PRIORITY DIAGNOSIS: *(check all that apply and specify ICD-10 CODE)*

- ☐ **Schizophrenia (F20.9)**
- ☐ **Schizophreniform Disorder (F20.81)**
- ☐ **Schizoaffective Disorder (F25.0)**
- ☐ **Schizoaffective Disorder (F25.1)**
- ☐ **Schizophrenia Spectrum/other Psychotic Disorder (F28)**
- ☐ **Unspecified Schizophrenia Spectrum/Other Psychotic Disorder (F29)**
- ☐ **Delusional Disorder (F22)**
- ☐ **Major Depressive Disorder -** Recurrent or Recent Episode, Severe w/o (F33.2) or w/Psychotic Features (F31.3)
- ☐ **Bipolar I Disorder –** Current or most Recent Episode, Manic Severe w/o (F31.13), or w/Psychotic Features (F31.2)
- ☐ **Bipolar I Disorder –** Current or most Recent Episode, Depressed, Severe w/o (F31.4), or w/Psychotic Features (F31.5)
- ☐ **Bipolar I Disorder –** Current or most Recent Episode, Hypomanic (F31.0), or Hypomanic Unspecified (F31.9)
- ☐ **Bipolar II Disorder – (F31.81)**
- ☐ **Schizotypal Personality Disorder (F21)**
- ☐ **Borderline Personality Disorder (F60.3)**

Axis I:

Axis Code:

Axis Code:

Axis Code:

Axis Code:

Diagnosis given by: Date:

Medications **NONE**

Type	Dosage/Frequency	Prescribed By:

(Please include additional MEDS in your summary)

Additional Comments/Concerns:

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Collaboration Agreement:

I, ______________________ (*Therapist Name and Title*), *agree to participate in team treatment planning sessions/initial session within two weeks of receipt of the referral and quarterly sessions in person or by phone.*

Please Attach Copies Of The Following:

1. **Current Psychosocial, Psychiatric or Psychological Evaluation**
2. **Court Order (If child is committed to DSS or DJS)**
3. **Current Therapist Treatment Plan**

FOR STEP OF FAITH STAFF USE ONLY

Date of Referral Received:__________________________**Received By:** __________________________________

Date Referral Source Contacted?______________________**Date Client Contacted:** __________________________

Value Options Authorization Date: _____________________