HEALTHY MINDS
Mental Health Therapy and Rehabilitation Services

PSYCHIATRIC REHABILITATION PROGRAM
ADULT/MINOR REFERRAL FORM

Consumer Name:		**D.O.B.:**
Guardian Name: **Does the Parent/Guardian have legal custody? Yes/No**		
Address:		
City:	**State:**	**Zip:**
Home number:	**Cell number:**	
MA/Medicaid #:		
Marital Status:	**Race:**	**Highest Level of Education:**
Is the individual eligible for full funding for Developmental Disabilities Administration services? YES/NO		
Have family of peer supports been successful in supporting the individual? YES/NO		
Is the primary reason for the individual's impairment due to an organic process of syndrome, intellectual disability, a neurodevelopmental disorder or neurocognitive disorder? YES/NO		

ICD-10 Primary Diagnosis Code:	
Diagnosing Clinician's Name, Credentials, and Title:	
Clinician's agency name and address:	
Clinician's Phone:	**Clinician's Email:**
Duration of current episode of treatment provided to this individual: ☐ Less than one month ☐ 2-3 months ☐ 4-6 months ☐ 7-12 months ☐ More than 12 months	
Current frequency of treatment provided to this individual: ☐ At least 1x/week ☐ At least 1x/2 weeks ☐ At least 1x/month ☐ At least 1x/3 months ☐ At least 1x/6 months	
In the past three months, how many ER visits has the individual had for psychiatric care? ☐ No visits in the last three months ☐ One visit in the last three months ☐ Two or more visits in the last three months	
Is the individual transitioning from an inpatient, day hospital or residential setting to the community setting? YES/NO	
Does the individual have Target Case Management referral or Authorization? YES/NO	
Has medication been considered for this individual? ☐ Not considered ☐ Considered and Ruled Out ☐ Initiated and Withdrawn ☐ Ongoing ☐ Other	

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IDENTIFY FUNCTIONAL IMPAIRMENT IN THE FOLLOWING AREAS (as applicable):
Inability to obtain/maintain competitive employment:
Inability to perform instrumental activities of daily living (g: shopping, meal preparation, laundry, basic housekeeping, medication management, transportation, and money management):
Inability to establish/maintain personal support system:
Deficiencies of concentration/persistence/pace leading to failure to complete tasks:
Inability to perform self-care (hygiene, grooming, nutrition, medical care, safety):
Marked deficiencies in self-direction, shown by inability to plan, initiate, organize and carry out goal directed activities:
Marked inability to procure financial assistance to support community living:
Evidence that the current intensity of outpatient treatment for this individual is insufficient to reduce the individual's symptoms and functional behavioral impairments resulting from mental illness:
Evidence of emerging risk to safety of the individual or others:
List specific ways PRP services are expected to help this individual:

REFERRING LICENSED PROVIDER COMPLETING THIS APPLICATION	
Print name:	
Signature:	**Date:**

_____ I am authorized or have been given authorization to give consent for Healthy Minds PRP to collaborate with service providers to receive and verify the information on this form for screening assessment purposes and to determine the appropriateness of services for above-referenced individual.

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