HEALTHY MINDS LLC
Outpatient Mental Health Center

PSYCHIATRIC REHABILITATION PROGRAM (PRP)

Minor Referral Form

Client Name:		**D.O.B.:**
Guardian Name: **Does the Parent/Guardian have legal custody? Yes/No**		
Address:		
City:	**State:**	**Zip:**
Home number:	**Cell number:**	**Email address:**
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** ☐		
Has the consumer received PRP services elsewhere in the last year? ☐ **YES/NO** ☐ **If YES, name of program:**		
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 ☐ Not considered ☐ Considered and Ruled Out ☐ Initiated and Withdrawn ☐ Ongoing ☐ Other		
If YES to medication, please list: **Name of Medications** **Dosage**		

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Rosedale, MD 21237
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PROVIDE SPECIFIC EXAMPLES of Functional Impairment in The Following Areas (as applicable):

Does the individual have academic problem? ☐ YES/NO ☐ If yes, provide details:

1. What is the problem?

2. Explain how the impairment is caused by client's mental health diagnosis:

3. Provide specific example of impairment:

Does the individual have problems complying to home/school/community rules? ☐ YES/NO ☐
If yes, provide details:

1. What is the problem?

2. Explain how the impairment is caused by client's mental health diagnosis:

3. Provide specific example of impairment:

Does the individual have problems with personal support system? ☐ YES/NO ☐
If yes, provide details:

1. What is the problem?

2. Explain how the impairment is caused by client's mental health diagnosis:

3. Provide specific example of impairment:

Does the individual have concentration problems leading to failure to complete tasks? ☐ YES/NO ☐
If yes, provide details:

1. What is the problem?

2. Explain how the impairment is caused by client's mental health diagnosis:

3. Provide specific example of impairment:

Does the individual have problems with self-care skills (hygiene, grooming, nutrition, medical care, safety)? ☐YES/NO☐ If yes, provide details: 1. What is the problem? 2. Explain how the impairment is caused by client's mental health diagnosis: 3. Provide specific example of impairment:
Does the individual have problems with self-direction, shown by inability to plan, initiate, organize and carry out age-appropriate goal directed activities? ☐YES/NO☐ If yes, provide details: 1. What is the problem? 2. Explain how the impairment is caused by client's mental health diagnosis: 3. Provide specific example of impairment:
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:

Collaboration Agreement

I, _____, agree to participate in initial and monthly treatment planning meetings with the Healthy Minds LLC Psychiatric Rehabilitation Program team in-person, by email or by phone.

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

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