INFINITE GROWTH ADULT-PRP REFERRAL FORM

Email referral form to: prpreferrals@infinitegrowthmd.com

Client Name: _____ MA#: _____DOB: _____ Race: _____
Address: _____Phone #_____
If client doesn't have Medical Assistance: SS#_____(uninsured span criteria must be met to qualify for services without MA)

I am referring the patient for the following services: ☐ Adult PRP ☐ [illegible]

Please Note: This is a two-page form. This form must be filled out in its entirety in order to allow for medical necessity and authorization for services. Please do not add diagnoses to this form.

Category A Diagnosis- Must meet either criteria 1 or 2 under "Additional Service Criteria Requirements" listed below.

☐ F20.81 Schizophreniform Disorder
☐ F20.9 Schizophrenia
☐ F22 Delusional Disorder
☐ F25.0 Schizoaffective Disorder, Bipolar Type
☐ F25.1 Schizoaffective Disorder, Depressive Type
☐ F28 Other Specified Schizophrenia Spectrum and other Psychotic Disorder
☐ F29 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
☐ F31.2 Bipolar I Disorder, Current or MRE Manic, /w Psychotic Ft
☐ F31.5 Bipolar I disorder, Current or MRE Depressed, /w Psychotic Ft
☐ F33.3 MDD, Recurrent Episode, /w Psychotic Features

Category B Diagnosis- Must meet criteria #2 under "Additional Service Criteria Requirements" listed below.

☐ F31 Bipolar I Disorder, Current or MRE Hypomanic
☐ F31.13 Bipolar I Disorder, Current or MRE Manic, Severe
☐ F31.4 Bipolar I Disorder, Current or MRE Depressed, Severe
☐ F31.81 Bipolar II Disorder, Unspecified
☐ F31.9 Bipolar Disorder, Current or MRE Unspecified
  - Current or MRE Hypomanic, Unspecified
  - Unspecified Bipolar and Related Disorder
☐ F33.2 Major Depressive Disorder, Recurrent Episode, Severe
☐ F60.3 Borderline Personality Disorder

Additional Service Criteria Requirements-

1. ☐ The individual is enrolled in SSI or SSDI
2. ☐ The referred individual demonstrates impaired functioning for at least two years as evidenced by at least **3** of the following criteria on a continuing or intermittent basis. Please include specifics-
   - **Marked inability to establish or maintain independent competitive employment**

     _____
     _____
   - **Marked inability to perform instrumental activities of daily living (Shopping, meal prep, household chores, med management, transportation, money management)**

     _____
     _____
   - **Marked inability to establish or maintain personal support system**

     _____
     _____
   - **Marked or frequent deficiencies of concentration, persistence, or pace**

     _____
     _____
   - **Marked inability to perform or maintain self-care (hygiene, grooming, nutrition, medical care, personal safety)**

     _____
     _____
   - **Marked deficiencies in self-direction**

     _____
     _____
   - **Marked inability to procure financial assistance to support community living**

     _____
     _____
3. ☐ Individual doesn't have two years of impaired functioning as required for a category B diagnosis, but they have a new onset category A diagnosis and PRP services are the most effective means to diminish risk.

Please provide specific examples to support the above selected impaired functions: (Individual must have at least 3 impaired functions)

Marked impaired function:

Provide specific concrete examples of THIS participant's impaired function.

Marked impaired function:

Provide specific concrete examples of THIS participant's impaired function.

Marked impaired function:

Provide specific concrete examples of THIS participant's impaired function.

Marked impaired function:

Provide specific concrete examples of THIS participant's impaired function.

4. Additional Clinical information

Primary Medical diagnoses:

_____

_____

Social Elements Impacting Diagnosis

☐ None	☐ Access to Health Care	☐ Housing Problems	☐ Social Environment
☐ Educational	☐ Legal System/Crime	☐ Occupational	☐ Homelessness
☐ Financial	☐ Primary Support	☐ Other Psychosocial/Enviro.	☐ Unknown

Current medications:

_____

_____

Is the individual med compliant: ☐yes ☐no

Present Symptoms: Please include hx of SI and HI

_____

_____

Criminal Hx: ☐yes ☐no

Please provide brief reason for referral:

_____

_____

Most recent Psychiatric Hospitalization_____ **Date**_____

_____ _____

Referring Mental Health Professional Signature and Credentials Date

_____ _____

Referring Professionals Name Location

_____ _____

Referring Professionals Phone number Email Address

_____ _____

Treating Psychiatrist Phone Treating Therapist Phone