IGCRC

Child & Adolescent Psychiatric Rehabilitation Program (PRP)

REFERRAL FORM

Email referral form to: prpreferrals@infinitegrowthmd.com

IDENTIFYING INFORMATION:

Child's Name:		**Date of Birth:**		**Age:**	
Address:		**Social Security #:**		**Sex:**	☐ Male ☐ Female
City, State, Zip:		**Medical Assistance #:**			
Phone#:		**Access to Transportation for On Site Activities:**			◯ Yes ◯ No
Adult Contact's Name:		**Relationship:**	☐ Parent ☐ Guardian ☐ Foster Care Provider		
Address (If different):		**Does Contact Person Have Legal Custody?**			◯ Yes ◯ No
City, State, Zip:		**Phone Number:**			

DSM V DIAGNOSES: (A minor must have a behavioral diagnosis and be referred by a Licensed MH Professional to be eligible for PRP.)

Behavioral Diagnoses: *(ICD-1 O Diagnosis Code Required)*	Diagnosis Code:		Description:	
	Diagnosis Code:		Description:	
	Diagnosis Code:		Description:	
Primary Medical Diagnoses: *(Required)*	Description:			
	Description:			
Social Elements Impacting Diagnoses: *(Required)*	None Educational Financial Access to Health Care Legal System/Crime Primary Support Housing Occupational Social Environment Homelessness *Other Psychosocial & Environmental Unknown *Explain "Other Psychosocial & Environmental elements:*			
Source of Diagnoses: *(Required)*		**Functional Assessment Functional Assessment**	Measure Used:	Score:

REASON FOR REFERRAL: (Indicate the areas you want the PRP to address.)

☐ **Self Care Skills:** *(Check all that apply)*	☐ personal hygiene/grooming	☐ dressing self	☐ toileting
	☐ nutrition/dietary planning	☐ following routines (bed, school)	☐ self administration of meds
☐ **Semi-Independent Living Skills:** *(Check all that apply)*	☐ taking care of belongings	☐ maintaining living area	☐ safety skills
	☐ money management	☐ mobility skills	☐ accessing entitlements
☐ **Interactive Skills with Others:** *(Check all that apply)*	☐ interactive skills with peers	☐ interactive skills with Family	☐ interactive skills with adults
☐ **Leisure/Social Skills:**	☐ community integration	☐ participation in activities	☐ developing natural supports
☐ **Anger Management Skills:**	*Add'l info (if needed):*		
☐ **Education:**	*Add'l info (if needed):*		
☐ **Symptom Management:**	*Add'l info (if needed):*		
☐ **Community/Family Resources:**	*Add'l info (if needed):*		
☐ **Other** *Exolain:*			

LICENSED MENTAL HEALTH PROFESSIONAL PROVIDING REFERAL:

Date:

Name & Credentials:		**Agency /Organization:**	
Street Address:		**Phone Number:**	
City, State, Zip:	Baltimore ,MD	**E-Mail Address:**	
Signature:		**Mental Health Treatment Currently Being Provided:**	☐ Outpatient Mental Health Services ☐ Inpatient Mental Health Services ☐ Residential Treatment Center

Attach a "Professional Assertion of Need for PRP Se,vices0 and a copy of the current Treatment Plan.

PRP Staff: Date Referral, Assertion of Need & Tx Plan Received:_____ Screening Scheduled within 5 days?: ◯ Yes ◯ No

(If no, attach Attempts to Schedule Screening form w info)

INFINITE GROWTH PRP-MINOR REFERRAL

Psychiatric Medications:

Is the Individual currently prescribed Medications? Yes No
List of Current Medications:

_____ _____
_____ _____
_____ _____

Additional Information:

Within the past 3 months, the emotional disturbance has resulted in:

1) A clear, current threat to the youth's ability to be maintained in their customary setting.

If yes, please provide evidence:

2) An emerging risk to the safety of the youth or others.

If yes, please provide evidence:

3) Significant psychological or social impairments causing serious problems with peer relationships and/or family members.

If yes, please provide evidence:

4) What evidence exists to show that the current intensity of outpatient treatment for this individual is insufficient to reduce the youth's symptoms and functional behavioral impairments resulting from mental illness?

5) Has the youth made progress toward age appropriate development, more independent functioning and independent living skills? Yes No

If YES, please describe the improvement.

If NO, please indicate changes in treatment plan to address lack of progress.

Has a crisis plan been completed with family and/or guardian? Yes No
Has an individual treatment plan/individual rehabilitation plan been completed? Yes No

SIGNATURE & CREDENTIALS OF LICENSED MENTAL HEALTH PROFESSIONAL PROVIDING REFERRAL: