# REFERRAL FORM

Date: _____

Client Name: _____ Medical Assistance #: _____
SSN: _____ M or F Ethnicity _____ DOB: _____ Age: _____
Address: _____ City: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Legal Guardian (if applicable) _____ Relationship (to client): _____ PH: _____
*Referring Agency: _____ Agency Contact (name/phone) _____
☐ DSS ☐ Group Home ☐ Therapist

**REASON FOR REFERRAL (Check all that apply)** ☐ Behavior/Conduct Challenges ☐ Emotional/Mental Illness ☐ Employment Instability
☐ Financial Instability ☐ Legal/Incarceration ☐ Medication Mismanagement ☐ Physical/Emotional Abuse
☐ Relational Conflicts ☐ Sexual Abuse ☐ Social/Interpersonal Challenges ☐ Substance Abuse ☐ Suicidal/Homicidal

**PRP SERVICES REQUESTED (Check all that apply)** ☐ Adaptive Resources ☐ Crisis Intervention ☐ Dangerous Behaviors ☐ Health Promotion
☐ Education/Vocational Training ☐ Independent Living Skills ☐ Promotion of Wellness, Self-Management, & Recovery ☐ Recovery Challenges
☐ Psychiatric ☐ Inpatient/Detention Center Support ☐ Self-Care Skills ☐ Social Relationships & Leisure Activities ☐ Social Skills

**SYMPTOMS AND BEHAVIORS/RISK BEHAVVIORS (Check all that apply)** ☐ Anxiety/Panic ☐ Attachment Problems ☐ Depressed
☐ Fire Setting ☐ Homicidal Ideations ☐ Hopeless/Helpless ☐ Hyperactive ☐ Impulsive ☐ Irritable ☐ Isolative
☐ Oppositional Defiant ☐ Lying/Manipulative ☐ Manic Mood ☐ Obsession/Compulsion ☐ Suicidal/Homicidal ☐ Physical Aggression
☐ Property Destruction ☐ Running Away ☐ Self-Care Deficit ☐ Self-Injurious Behavior ☐ Separation Problems ☐ Social/Withdrawal
☐ Sexually Inappropriate ☐ Stealing ☐ Suicidal Ideations ☐ Trauma-related ☐ Truancy ☐ Verbal Aggression

_____

Please indicate current ICD 10 diagnoses & relevant medications: (Each Axis must be completed, as well as GAF)

Diagnosis: _____

Diagnosis given by: _____ Date: _____

Is there psychosocial/assessment attached to verify this diagnosis? ☐ YES ☐ NO

Is the individual on medication? ☐ YES ☐ NO
**What medication? _____ Dosage _____ Frequency _____**
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**If no, please explain why the client is not on medication.**
_____
_____
_____

Has the participant been seen at least 4 times in the two months prior to or on the referral date, by the person making the referral to PRP? ☐ YES ☐ NO
**Date of Service – 1 _____ Date of Service – 2 _____ Date of Service – 3 _____ Date of Service – 4 _____**

Therapist Agency: _____ Phone: _____
Therapist Name: _____ Title: _____
Therapist Signature: _____ License Number: _____

Supervisor Name: _____ Title: _____
Supervisor Signature: _____ License Number: _____

Interpretative Summary:

_____

_____

_____

_____

_____

_____

_____

*******RECOMMENDED TYPE OF THERAPY:* ☐ MOBILE ☐ OFFICE ☐ RESISTANT TO THERAPY *******

**Please attach client's most recent psychosocial and/or psychiatric evaluation in addition to client's most recent treatment plan when submitting a referral.**