INTEGRATIVE
THERAPEUTIC SOLUTIONS, LLC.

Referral for Psychiatric Rehabilitation Program (Child-PRP)

Referral Source Information: ☐ Initial ☐ Re-Referral

Name of person / agency making referral:		**Date of Referral:**	
Address:			
City/ State/ Zip Code			
Mental Health Treatment Being Provided	☐ Outpatient Mental Health Services ☐ Inpatient Mental Health Services ☐ Residential Treatment Center		

Consumer Information:

Name:			**Date of Birth:**	**Age:**	
Address:		**City, State, Zip:**			
Sexual Orientation	☐ **Heterosexual** ☐ **Gay/Lesbian** ☐ **Bisexual** ☐ **Something Else, Please Describe:** ☐ **Don't Know** ☐ **Decline**		**Language Preference:**		
Race/Ethnicity:	☐ **Amer. Indian/Alaskan Native** ☐ **Asian** ☐ **White** ☐ **Black/African American** ☐ **Native American / Hawaiian or Other Pacific Islander** ☐ **Hispanic** ☐ **Non-Hispanic**				
Gender Identification	☐ **Male** ☐ **Female** ☐ **Transgender Male/Trans Man/(F to M)** ☐ **Transgender Female/Trans Woman/(M to F)** ☐ **Genderqueer (or gender nonconforming)** ☐ **Additional Gender Category, please specify:** ☐ **Decline**				
Social Security Last 4 digits#:		**MA#**			
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:**			

Presenting Symptoms: (Please include History of Illness)

Severity of Illness/Areas to Address: Self-Care, Independent Living, Anger, Education, Social Skills, Symptom Management, Community/Family Resources

3200 Crain Highway Ste. 205
Waldorf, MD 20603
Phone: (240) 448-2475
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Intensity of Services to treat Illness/ Professional/Clinical justification for PRP level of care

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

Primary Behavioral Diagnosis:	Diagnosis Code:		Description:	
Secondary Behavioral Diagnosis:	Diagnosis Code:		Description:	
Tertiary Behavioral Diagnosis:	Diagnosis Code:		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 Diagnosis: *(Required)*		**Functional Assessment** *(If applicable)*	Measure Used:		Score:	

This individual has a serious mental illness which has required the intervention of the Public Mental Health System in the last two years: Yes☐ No☐

How long has the client been in therapy? _____

How many hospital visits have there been in the last three months for psychiatric care? _____

Is the client using any illicit substances or alcohol? Yes☐ No☐ If so, list the substances and the frequency _____
_____

Current Medications:
_____

Is the individual med compliant: Yes☐ No☐

Mental Health Practitioner:

Name:	Date:
Signature:	Date:

Attach a "Professional Assertion of Need for PRP Services" 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**

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