Psychiatric Rehabilitation Program
4000 Blackburn Lane, Burtonsville, MD 20866
T|301-421-4241|

Referral Form

To qualify for PRP services, all of the following criteria are necessary for admission:

1.The adult participant has a PBHS specialty mental health DSM-5 diagnosis. Minors are automatically considered priority for approval.
2. The participant's behavior(s) or impairment(s) can be expected to improve at this level of care.
3. The participant's conditions requires PRP services to develop independent living skills to assist the participant's recovery.
4. The participant doesn't require an intensive level of care.

Referral can be sent to the following address: **referrals@csolutionsmh.com**.

Date of Referral: _____

Client Information

Client Name: _____ Age: _____ D.O.B: _____
Address: _____ City: _____ State: ___ ZIP: _____
SSN: _____
Ethnicity: _____ Gender: Male____ Female____ Other: _____
Phone Number of Client (if applicable): _____

School/ Education Information:

☐ **Section Not Applicable**

Current Grade Level : _____ Last Completed Grade Level: ___Current school: _____
Previously Attended School (if applicable): _____
Is the client in special education? Y or N
Is the client attending a non-public school? Y or N
Does the client have a 504 Plan? Y or N

Residential Arrangement:

____With Relative(s) ___Homeless/Shelter ___Group Home ___ Lives Alone in Community
___ Other: _____

Legal History:

Has the client ever been arrested? Y or N
If so, does the client have any previous or current Juvenile Services Involvement? Y or N

Therapy

Is the client currently receiving therapy? (Circle one) Y or N
Therapist Printed Name: _____ **Date:** _____ **Phone:** _____
Therapist Signature: _____ **Credentials:** _____

Please specify current DSM-V diagnoses & medications:
Diagnosis: _____ **Diagnosis Code (if known):** _____
Medication(s): _____

Diagnosis: _____ **Diagnosis Code (if known):** _____
Medication(s): _____
Diagnosis given by (Print name): _____ **Credentials:** _____ **Date:** _____

Clinical Information

Symptoms and Behaviors (check all that apply):

☐ Depressed	☐ Physical Aggression	☐ Hyperactive
☐ Anxiety/Panic	☐ Theft	☐ Lying
☐ Hopelessness	☐ Suicidal Ideation	☐ Property Destruction
☐ Impulsivity	☐ Trauma	☐ Running Away
☐ Isolation	☐ Lack of Self-Care	☐ Mania
☐ Obsession/Compulsion	☐ Attachment Issues	☐ Irritability

If additional symptoms, please explain:

_____

_____

Has the client ever been hospitalized? Y or N
If so, what are the client's total number of hospitalizations? _____
Location and Date of recent hospitalization: _____