HANDS OF HOPE
THERAPEUTIC SERVICES

Anne Arundel County
2131 Espey Court Suite 6, Crofton , MD 21114
Phone: (443) 494-8477
Fax: (443) 302-2545
info@hohts.com www.hohts.com

PSYCHIATRIC REHABILITATION PROGRAM REFERRAL

☐ **Initial**

Date : _____ Person-Served Name: _____

Demographic Information: (Please complete all sections in its entirety). Must be signed and dated.

DOB:_____ Age:_____ Gender _____

SS#:_____Race: _____

Highest grade Completed:_____

Street Address: _____

City:_____ State: _____ Zip:_____

Home Phone: _____ Cell/Work:_____

Email: _____

Physical Description:

Emergency Contact (Relationship to Person-Served): _____

Contact's Phone#_____ (Work/Mobile):_____

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Type of living situation:

[ ] Private residence alone or with Friend/Roommate [ ] Private Residence with Family

[ ] Homeless/Emergency Shelter [ ] Halfway House [ ] Boarding/rooming house with No Supervision [ ] RRP, Group home [ ] Crisis Residence [ ] Assisted Living [ ] Hospital

[ ] Jail/Correctional facility/Detention Center

Other:_____

Current Status

_____ Outpatient

_____ Inpatient-projected release date:_____

_____ Partial Hospitalization-projected release date: _____

_____ Crisis Bed/Other crisis facility-projected release date: _____

_____ Other: _____

When was most recent inpatient discharge: _____

Data Standard for Primary Language

1. Do you speak a language other than English at home?

a. [ ] Yes b. [ ] No

For persons speaking a language other than English (answering yes to the question above):

2. What is this language?

a. [ ] Spanish b. [ ] Other Language (Identify)_____

Insurance:

Insurance Type: [ ] Medicaid #_____

SSI monthly amount: _____ SSDI Monthly amount _____

Other Source of Income _____

Does client have any other type of insurance? [ ] Yes [ ] No If yes,

Name_____

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PRP CRITERIA FOR ADULTS: Attach copy of Psychosocial Assessment to referral. (If available)

DSM and ICD10 diagnosis codes: **Individual must meet one of the following targets diagnostic code to qualify for PRP services.**

F20.9 ( )	**Schizophrenia**	**F20.81 ( )**	**Schizophreniform Disorder**	**F25.0 ( )**	**Schizoaffective Do. Bipolar Type**
F25.1 ( )	**Schizoaffective Do, Dep Type**	**F22 ( )**	**Delusional Do**	**F28 ( )**	**Other Specified Schizophrenia Spectrum and Other Psychotic D..**
F29 ( )	**Unspecified Schizophrenia spectrum and Other Psychotic Do.**	**F33.2 ( )**	**MDD, Recurrent Ep. Severe**	**F33.3 ( )**	**MDD, Recurrent Epi. with Psychotic Features**
F31.13 ( )	**Bipolar 1 Do. Current or most Recent Epi. Manic, Severe**	**F31.2 ( )**	**Bipolar 1 Do. Current or most recent Epi. Manic with psychotic Features.**	**F31.4 ( )**	**Bipolar 1 Do. Current or Most Recent Epi Depressed, Severe**
F31.5 ( )	**Bipolar 1 Do. Most recent Epi. Depressed with Psychotic Features**	**F31.0 ( )**	**Bipolar 1 Do. current or Most Recent Hypomanic**	**F31.9 ( )**	**Bipolar 1 Do. Current or Most Recent Episode Unspecified**
F31.9 ( )	**Bipolar 1 Do. Current or Most Recent Epi. Hypomanic, Unspecified**	**F31.9 ( )**	**Unspecified Bipolar and Related Disorder**	**F31.81 ( )**	**Bipolar 11 Disorder**
F21 ( )	**Schizotypal Personality Disorder**	**F60.3 ( )**	**Borderline Personality Do.**		

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Additional Behavioral Health Diagnosis:

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Primary Medical Diagnosis:

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Social Elements Impacting Diagnosis: (check all that apply)

___ None

___ Problems with access to health care services

___ Homelessness

___ Housing problems (Not homelessness)

___ Problems related to social environment

___ Educational Problems

___ Problems related to interaction with legal system crime.

___ Occupational Problems

___ Financial Problems

___ Problems with primary support group

___ Other psychosocial and environmental problems

___ Unknown

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Narrative: Please explain specific issues that the client is experiencing and how PRP will help assist client to improve in all areas of need. (Current symptoms and functional limitations). What are driving symptoms and how do they impact daily functioning? Tried any less intensive services such as group therapy, targeted case management or peer support/family? Why have outpatient services been insufficient?

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Reasons for seeking treatment.

____ Coordination of current community services

____ Linkage to community resources/community integration

____ Prevention/reduction of hospitalization or rehospitalization

____ Facilitating transition from more intensive services

Does person-served have a history of suicidal/homicidal/suicidal ideation with or without a plan/self-injurious behaviors? Or physical/verbal aggression towards other?

Have there been any medication compliance issues? History of psychiatric hospitalizations?

Any allergies to food or medications? If yes to any, briefly explain.

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Collaboration Agreement: (Please sign and date)

I _____**(Clinician/Dr Name and Cred),** refer _____ **(Person-served name)** and agree to collaborate with the PRP staff regarding the client's rehabilitation treatment including re-referral request, scheduled treatment sessions, and emergency team treatment planning sessions for referred person-served.

Clinician's Printed Name w/Credentials:_____

Clinician's Signature

w/Credentials:_____

Agency:_____

Address:_____ **City**_____

State: _____ **Zip Code:** _____

Phone #: _____ **Fax #:** _____

Referral must be signed by an independently licensed mental health professional, physician, or psychiatric nurse practitioner (LCPC, LCSW-C, MD (Psychiatrist), Psychologist, or CRNP-PMH). All LG's, PA and PA-C must have supervisor signature provided on referral as well.

FOR OFFICE USE ONLY: Date referral received: _____