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**Waldorf Location: 11637 Terrace Dr., Ste 201. Waldorf, MD 20602**

**Landover Location: 4301 Garden City Drive, Ste. 304, Landover, MD 20785**

**Email: referrals@kihealthareservices.com**

**Phone: 240-419-3803 or 240-667-1679**

**Fax: 240-667-1712**

**Psychiatric Rehabilitation Program Referral**

**Demographic Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

US Citizen or Legal Resident: ο Yes ο No ο Homeless ο At Risk of Homelessness

Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_ Does individual have a: Legal Guardian: ο Yes ο No

Power of Attorney: ο Yes ο No Has Guardian been notified of this referral? (Please provide the guardianship documents or POA) ο Yes ο No

Is the client aware of this referral? ο Yes ο No

Gender identity: ο Male ο Female ο Gender Fluid ο Transgender Male ο Transgender Female ο Gender queer

Race: ο White ο Black or African American ο Asian ο Native Hawaiian or Pacific Islander ο American Indian or Alaska Native ο Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity: ο Non-Hispanic/Non-Latino ο Hispanic/Latino: (circle) Central American, Cuban, Dominican, Mexican/Chicano, Puerto Rican, South American

Interpreter needed: ο Yes ο No Please specify language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Income Sources and Amounts: SSI\_\_\_\_\_, SSDI\_\_\_\_\_, PAA\_\_\_\_\_, Food Stamps\_\_\_\_\_, Other\_\_\_\_\_\_ Rep Payee ο Yes ο No

Insurance: Medical Assistance (Medicaid)#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Private Insurance ο Yes ο No

What is the primary priority population diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Legal Status (i.e. parole, probation, conditional Release, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Behavioral Health reasons for referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Barriers to Independence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have client been referred to Supported Employment (SEP)? ο Yes ο No If no, why not? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have client been referred to Group Therapy? ο Yes ο No If no, why not? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have client been referred to Targeted Case Management (TCM)? ο Yes ο No If no, why not? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Risk Taking Behaviors (incl Hx of Violence, Aggression, and Substance Abuse): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Source: Name, credentials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone or email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Maryland Behavioral Health Administration requires a referral by a mental health professional for all adults being referred to or receiving Psychiatric Rehabilitation Program (PRP) services. This document permits mental health professionals to submit both requirements in a single document.

I am verifying that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ needs services from K&I Psychiatric Rehabilitation Program.

Services needed include assessment and continued on-site and/or off-site psychiatric rehabilitation services and crisis management. This service is medically necessary to facilitate the client’s wellness and recovery and is based on my assessment of need in the following areas:

**Please check all that apply.**

\_ Inability to establish or maintain employment (pattern of unemployment, underemployment or sporadic work history)

\_ Inability to perform instrumental activities of daily living (shopping, meal preparation laundry, basic housekeeping, medication management, transportation and money management)

\_ Inability to establish or maintain personal relationships (social withdrawal or isolation, interpersonal conflict or social behavior, other than criminal that is not easily tolerated by the community)

\_ Deficiencies of concentration, persistence, or pace (failure to complete in a timely manner tasks commonly found in work, school or home settings)

\_ Inability to perform or maintain self-care (hygiene, grooming, nutrition, medical care, personal safety)

\_ Deficiencies in self-direction (inability to independently plan, initiate, organize and carry out goal directed activities)

\_ Inability to procure financial assistance to support community living

Please briefly describe the client’s need for PRP services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorizations require a DSM-5/ICD-10 diagnosis.**

Primary ICD-10 Behavioral Health Diagnosis Code \_\_\_\_\_\_\_\_\_\_ Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional ICD-10 Behavioral Health Diagnosis Code \_\_\_\_\_\_\_\_\_\_ Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Code \_\_\_\_\_\_\_\_\_\_ Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Code \_\_\_\_\_\_\_\_\_\_ Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Code \_\_\_\_\_\_\_\_\_\_ Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorizations require a listing of prescribed medications to treat DSM-5/ICD-10 diagnoses.**

Medication 1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication 2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication 3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature and Title/Licensure of Mental Health Professional Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Clinician NPI#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician Name Printed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Masters or Graduate Level Supervisor Name, if applicable COMAR requires all Residential Rehabilitation, Psychiatric Rehabilitation, and Community Employment providers obtain a referral from a fully licensed mental health professional at the time of referral and every 6 months thereafter.