K&I Healthcare Services
Maryland's Leading Providers for Outpatient Mental Health & Recovery

PRP REFERRAL FORM

Date: _____

REFERRAL SOURCE (AGENCY/PERSON): _____

Referring Provider Name and Credentials: _____

ADDRESS _____

PHONE _____

FAX NUMBER _____ EMAIL ADDRES_____

CONSUMER'S NAME _____ DOB _____ Adult or Child? (Circle)

AXIS I Diagnosis Code & Diagnosis (Note: Priority Population Diagnosis is required for Adults for PRP services):

_____

MEDICAID. # _____ GENDER ____ AGE ____

RACE _____ ETHNICITY _____

ADDRESS _____

HOME PHONE _____ WORK HOME _____

EMAIL _____

HAS CHILD BEEN IN SCHOOL WITHIN THE LAST 3 MONTHS? ☐Yes ☐No WHAT IS CURRENT OR HIGHEST GRADE COMPLETED? ____

IF ADULT, WHAT IS THE HIGHEST GRADE COMPLETED?___HAS CONSUMER BEEN ARRESTED IN LAST 30 DAYS? YES/NO # OF TIMES ____

BIOLOGICIAL PARENT OR LEGAL GUARDIAN (MUST PROVIDE LEGAL DOCUMENTS FOR VERIFICATION)

NAME _____ Relationship: _____
ADDRESS_____

HOME PHONE _____ WORK PHONE _____

3200 CRAIN HWY SUITE 304
WALDORF, MD, 20603
(240) 419-2931

4301 GARDEN CITY DRIVE SUITE 303
LANDOVER, MD 20785
(240) 667 -1679

EMERGENCY CONTACT (IF DIFFERENT THAN LEGAL GUARDIAN) _____

HOME PHONE _____ WORK HOME _____

ATTORNEY (NAME AND AGENCY IF APPLICABLE) _____

ADDRESS _____ OFFICE PHONE _____

PREFERRED METHOD OF SERVICE DELIVERY (CHECK ALL THAT APPLY)
☐ IN PERSON ☐ VIRTUAL ☐ HYBRID (BOTH VIRTUAL AND IN PERSON)

CURRENT THERAPIST AND CREDENTIALS: _____

PSYCHIATRIST AND CREDENTIALS: _____

BRIEF DESCRIPTION OF PROBLEM (ATTACH SEPARATE SHEET IF NECESSARY. PLEASE FORWARD MEDICAL & BEHAVIORAL INFORMATION, COURT REPORTS, SOCIAL SUMMARIES, PREVIOUS EVALUATIONS, ETC.)

_____

ANY URGENT OR EMERGENCY NEEDS:

_____

SUBSTANCE ABUSE? YES ☐ NO ☐ IF YES, ACTIONS TAKEN (I.E REFERRAL)

_____

Referring Provider's Signature and Credentials: _____Date: _____

Referring Provider's Printed Name and Credentials: _____

Consumers Signature: _____Date: _____

Legal Guardian Signature (required for minors): _____Date: _____

_____

Consumer signature required below for Release of Information for referring clinician and agency to communicate for optimal mental health care. This communication permission will expire one year from the date below and can include:

- treatment plans
- diagnostic assessments
- insurance updates
- identification forms

Consumers Signature: _____

Date: _____

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Legal Guardian Signature (required for minors): _____

Date: _____

PLEASE EMAIL THIS COMPLETED FORM TO REFERRALS@KIHEALTHCARESERVICES.COM

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