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**Waldorf Location: 11637 Terrace Drive, Suite 201 Waldorf, MD 20602**

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

**Email: referrals@kihealthareservices.com**

**Phone: (Landover) 240-667-1679 and (Waldorf) 240-419-3803**

**Fax: 240-667-1712**

**Psychiatric Rehabilitation Program Referral**

**Demographic Information:**

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

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

Is the client aware of this referral? \_\_ Yes \_\_ No

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

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

Insurance: Medical Assistance (Medicaid)#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Private Insurance \_\_Yes 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Somatic Health and needs for Assistive Technology: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facility (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ need 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 an ICD-10 diagnosis.**

Please provide the information below for authorization.

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

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

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

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

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

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

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

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

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.