**PRP Referral Form**

To type within the PRP Referral, please single (left) click within the gray underlined box and start typing.

Referral Date:

Client Name:       DOB: Medical Assistance #:

Gender:       Gender Identity:       Marital Status:       Race:

Address:       Zip code:      Phone:

Legal Guardian (if minor):      Relationship (to minor):

Legal Guardian Address (if different from above):

Home Phone:       Cell Phone:       Work Phone:

School Name:       Address:       Phone:       Grade:

**Referral Source Information:**

Referring Agency/Therapist Name:       Credentials:

Phone:       Fax:       Email Address:

If not an independent licensed clinician please provide the following:

Clinical Supervisor’s Name/Credentials:

**Outpatient Treatment Information:**

Ongoing Therapist (if different than referring therapist):       Credentials:

Phone:       Fax:       Email Address:

If not an independent licensed clinician please provide the following:

Clinical Supervisor’s Name/Credentials:

Current frequency of treatment provided to this individual:

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | At least 1x /wk |  | At least 1x /2wks |  | At least 1x /mo |  | At least 1x /3mos |  | At least 1x /6mos |

How long has this individual been engaged in active, documented outpatient treatment?

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Less than 1 mo |  | 2-3 mos |  | 4-6 mos |  | 7-12 mos |  | More than 12 mos |

In the past 3 months, how many ER visits has the youth had for psychiatric care?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | None |  | One |  | Two or More |

Is the youth transitioning from an inpatient, day hospital or residential treatment setting to a community setting?

**Please list Current DSM-5 Diagnoses and Codes / ICD-10-CM:**

Please see the attached Priority Population Diagnosis List for Adults <https://maryland.optum.com/content/dam/ops-maryland/documents/provider/providerresources/Appendix%20C%20PPD%20List_Updated%201.12.21.pdf>

Diagnosis Given By:       Date:

**Reason for Referral, Symptoms, and Behaviors: Please check all that apply and provide specific details**

|  |  |
| --- | --- |
|  | Medical / Somatic |
|  | Physical/Emotional/Sexual Abuse |
|  | Medication Compliance |
|  | Suicidal/Homicidal Risk |
|  | Behavior Challenges |
|  | CPS Involved |
|  | Risk of Out-Of-Home Placement |
|  | Legal/Incarceration |
|  | Substance Abuse, client or family |
|  | Employment Instability/Financial Difficulty |
|  | Self-Care Deficit / Self-Care Training |
|  | Social/Interpersonal Skill Development |
|  | Illness Management |
|  | Family Support |
|  | Anger Management /Conflict Resolution |
|  | Independent Living /Life Skills Training |

|  |  |
| --- | --- |
|  | Anxiety / Panic |
|  | Property Destruction |
|  | Irritable |
|  | Separation Anxiety |
|  | Hyperactive |
|  | Impulsive |
|  | Physical Aggression |
|  | Self-Injurious Behavior |
|  | Suicidal Ideations |
|  | Depressed Mood |
|  | Homicidal Ideations |
|  | Sexually Inappropriate |
|  | Running Away |
|  | School Problems/Suspension |
|  | Other |

**Medical Necessity Criteria (MNC)**

Functional Criteria (For Minors):

1. Within the past 3 months, the youth’s emotional disturbance resulted in:

|  |  |  |
| --- | --- | --- |
|  | A clear, current threat to the youth’s ability to be maintained in their customary setting? | If yes, please provide specific details why: |
|  | An emerging risk to the safety of the youth or others? | If yes, please provide specific details why: |
|  | Significant psychological or social impairments causing serious problems with peer relationships and/or family members | Please provide specific details why: |

1. What evidence exists to show that the current intensity of outpatient treatment for this youth is insufficient to reduce the youth’s symptoms and functional behavioral impairments resulting from their mental health diagnosis/diagnoses? Please explain in specific clinical details:
2. How will PRP serve to help this youth get to age appropriate development, more independent functioning, and independent living skills?

Functional Criteria (For Adults)

Functional Impairments: *(Please answer the following questions below and provide specific examples, evidence, or symptoms related directly to the client’s primary priority population diagnosis)*

1. Does the client have marked inability to establish or maintain competitive employment?
2. Does the client have marked inability to perform instrumental activities of daily living, like shopping, meal preparation, laundry, housekeeping, medication management, transportation, or money management?
3. Does the client have marked inability to establish or maintain a personal support system?
4. Does the client have marked deficiencies of concentration/persistence/pace leading to failure to complete tasks?
5. Does the client have marked inability to perform self-care (i.e. hygiene, grooming, nutrition, medical care, safety)?
6. Does the client have marked deficiencies in self-direction, shown by inability to plan, initiate, organize, and carry out goal-directed activities?
7. Does the client have marked inability to procure financial assistance to support community living?
8. Other evidence of marked impairment that prevents optimal functioning?

**Health Related Information:**

Is client on medication?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Please list medication(s) and dosage:

If on medication, please identify client’s ability to take prescribed medication:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Independently |  | With Reminders |  | With Daily Supervision |  | Refuses Medication |

If not on medication, please indicate if medication was:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Not Considered |  | Considered and Ruled Out |  | Initiated and Withdrawn |  | Ongoing |

History of Hospitalizations:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

If yes, please indicate place and date of hospitalization:

List known medical history:

Is the client diagnosed with a medical condition?

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Obesity |  | Asthma |  | Diabetes |  | High Blood Pressure |  | COPD |  | Other |

What is the client’s most recent blood pressure reading?**Date of reading:**

Primary Care Physician or Medical Clinic:       Address:       Phone:

**Additional Needed Information:**

Have TBS or PRP services been tried in the past?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | Yes |  | No |

If yes, was it effective?

Please describe recommended components for client’s crisis plan:

**Referral Source’s Signature/ Credentials:**       **Date:**

*(Must be a Mental Health Professional)*

If not an independent licensed clinician, then please provide the following:

**Clinical Supervisor’s Name/Credentials:**  **Date:**

*(LMSW, must have a board approved social work clinical supervisor)*