**REFERRAL FORM**

|  |  |  |
| --- | --- | --- |
| **Client Name:** | **Date of Referral:**  | **Medical Assistance#:** |
| **SSN:** | **Gender:** | **Race:** |
| **DOB:** | **Age:** |  |
| **Home Phone:** | **Cell Phone:** | **Work phone:** |
| **Address:** |
| **City:** |
| **State:** | **Zip:** |
| **Legal Guardian If applicable:** | **Relationship:** |
| **Living Situation:** |
|  |
| **PRIMARY DIAGNOSIS:** |
| **Axis I:** |
| **Axis II:** |
| **Axis III:** |
| **Axis IV:** |
| **Axis V:** |
| **GAF:** |
| **Diagnosis given by:**  |
| **Date of diagnosis:** |
|  |
| **Is there documentation to verify this diagnosis?** **[ ]  yes** **[ ]  no** |
| **Is the client currently receiving therapy?** **[ ]  yes** **[ ]  no** |
| **Medications:**  |

**Presenting Problems, Current Symptoms & Additional Information:**

Briefly describe individual’s current problems, symptoms and needs for community support. Include any information that you feel will assist in determining eligibility and admission to into Support By Design PRP-M Program.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Referral (check all that apply):**

**[ ] Behavior/Conduct Challenges** **[ ] Emotional**

**[ ] Financial Instability** **[ ] Legal/Incarceration**

**[ ] Medication Mismanagement** **[ ] Educational Problems**

**[ ] Relational Conflicts** **[ ] Sexual Abuse**

**[ ] Social/Interpersonal Challenges** **[ ] Employment Instability**

**[ ] Suicidal/Homicidal**

**[ ] Physical/Emotional Abuse**

**[ ] Substance Abuse**

**PRP Services Requested (check all that apply):**

**[ ] Adaptive Resources** **[ ] Crisis intervention**

**[ ] Education/Vocational Training** **[ ] Health Promotion**

**[ ] Self-Care Skills** **[ ] Social Skills**

**[ ] Psychiatric Inpatient/Detention Center Support**

**[ ] Social Relationships & Leisure Activities**

**[ ] Promotion of Wellness, Self-Management & Recovery**

**[ ] Dangerous Behaviors**

**[ ] Independent Living Skills**

**Symptoms and Behaviors/Risk Behaviors (check all that apply):**

**[ ] Anxiety/Panic** **[ ] Attachment Problems** **[ ] Depressed** **[ ] Fire Setting**

**[ ] Hopeless/Helpless** **[ ] Hyperactive** **[ ] Impulsive** **[ ] Irritable**

**[ ] Lying/Manipulative** **[ ] Manic Mood** **[ ] Obsession/Compulsion** **[ ] Isolative**

**[ ] Property Destruction** **[ ] Running Away** **[ ] Self-care Deficit**

**[ ] Sexually Inappropriate** **[ ] Social Withdrawal** **[ ] Stealing**

**[ ] Truancy** **[ ] Verbal Aggression** **[ ] Oppositional Defiant**

**[ ] Self-injurious Behavior** **[ ] Suicidal Ideation**

**[ ] Homicidal Ideations** **[ ] Physical Aggression**

**[ ] Separation Problems** **[ ] Trauma-related**

|  |
| --- |
| **REFERRING THERAPIST (must be licensed therapist)** |
| **Name:** | **Date:** |
| **Phone:** | **Fax:** |
| **Credentials:** |
| **Email:** |
| **Agency:** |
| **LCSW-C License #:** |
| **LCPC License #:** |
| **\_\_\_\_\_\_\_\_\_\_ License #:**  |
|  |

**Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**