**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**