Support By Design, Inc.
Psychiatric Rehabilitation Program
3013 Montebello Tr.
Baltimore, MD 21214
443-927-7856 ext. 3
Fax#: 443-449-6543 eFax#: 443-927-8897
supportbydesignllc.com

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**
- ☐ **Financial Instability**
- ☐ **Medication Mismanagement**
- ☐ **Relational Conflicts**
- ☐ **Social/Interpersonal Challenges**
- ☐ **Suicidal/Homicidal**
- ☐ **Physical/Emotional Abuse**
- ☐ **Substance Abuse**
- ☐ **Emotional**
- ☐ **Legal/Incarceration**
- ☐ **Educational Problems**
- ☐ **Sexual Abuse**
- ☐ **Employment Instability**

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PRP Services Requested (check all that apply):

- ☐ Adaptive Resources
- ☐ Education/Vocational Training
- ☐ Self-Care Skills
- ☐ Psychiatric Inpatient/Detention Center Support
- ☐ Social Relationships & Leisure Activities
- ☐ Promotion of Wellness, Self-Management & Recovery
- ☐ Dangerous Behaviors
- ☐ Independent Living Skills
- ☐ Crisis intervention
- ☐ Health Promotion
- ☐ Social Skills

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

- ☐ Anxiety/Panic
- ☐ Hopeless/Helpless
- ☐ Lying/Manipulative
- ☐ Property Destruction
- ☐ Sexually Inappropriate
- ☐ Truancy
- ☐ Self-injurious Behavior
- ☐ Homicidal Ideations
- ☐ Separation Problems
- ☐ Attachment Problems
- ☐ Hyperactive
- ☐ Manic Mood
- ☐ Running Away
- ☐ Social Withdrawal
- ☐ Verbal Aggression
- ☐ Depressed
- ☐ Impulsive
- ☐ Obsession/Compulsion
- ☐ Self-care Deficit
- ☐ Stealing
- ☐ Oppositional Defiant
- ☐ Suicidal Ideation
- ☐ Physical Aggression
- ☐ Trauma-related
- ☐ Fire Setting
- ☐ Irritable
- ☐ Isolative

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

Therapist Signature: _____