

Psychiatric Rehabilitation Program (PRP) Referral Form

Identifying Information:

Client's Name: _____ Age: _____ Transition Age Youth? Y/N D.O.B. _____
Address: _____
City: _____ State: _____ Zip: _____
Daytime Number: () _____ Home/Other: () _____
Social Security Number: _____
Race: _____ Ethnicity: _____ Marital Status: _____ Gender: _____ Current Level of Education: _____
Insurance Type: _____ Medicaid #: _____ Authorized: YES NO
Does the Parent/Guardian have legal custody of the minor? YES NO N/A
If they are an adult, do they have a legal guardian? YES NO N/A
If parent does not have custody, please provide custodial information:
Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

****Please note: Services cannot begin unless proof of custody is provided.****

MEDICAL NECESSITY CRITERIA Psychiatric Rehabilitation Program Services (PRP)

Name of Client

Referring Clinician and Credential

Diagnosis: Please use ICD 10 codes
Diagnosed by:

Date

**Diagnosis: please indicate current DSM diagnoses. (MUST HAVE AXIS I DIAGNOSIS)
ADULTS MUST HAVE ONE OF THE FOLLOWING DIAGNOSIS FOR PRP ELIGIBILITY**

295.90/F20.9 Schizophrenia 295.40/F20.81 Schizophreniform Disorder
295.70/F25.0 Schizoaffective Disorder, Bipolar Type 295.70/F25.1 Schizoaffective Disorder, Depressive Type
298.8/F28 Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
298.9/F29 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
297.1/F22 Delusional Disorder
296.33/F33.2 Major Depressive Disorder, Recurrent Episode, Severe
296.34/F33.3 Major Depressive Disorder, Recurrent Episode, W/ Psychotic Features
301.22/F21 Schizotypal Personality Disorder
296.43/F31.13 Bipolar I Disorder, Current or Most Recent Episode Manic, Severe

296.44/F31.2 Bipolar I Disorder, Current or Most Recent Episode Manic Psychotic Features
296.53/F31.4 Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe
296.54/F31.5 Bipolar I Disorder, Most Recent Episode Depressed, With Psychotic Features
296.40/F31.9 Bipolar I Disorder, Current or Most Recent Episode Hypomanic
296.40/F31.9 Bipolar I Disorder, Current or Most Recent Episode Hypomanic, Unspecified
296.70/F31.9 Bipolar I Disorder, Current or Most Recent Episode Unspecified
296.80/F31.9 Unspecified Bipolar and Related Disorder
296.89/F31.81 Bipolar II Disorder 301.81/F60.3 Borderline Personality Disorder

Reason for Referral/Rehabilitation Needs (PLEASE BE SPECIFIC)

[Type here]

Is the client currently on psychotropic medications? Yes No

If yes, please list all medications_____

☐ Has the client recently been discharged from an outpatient Mental Health Facility/ Hospital: Yes No
(If yes, have they provided a copy of the aftercare plan?) : Yes No

☐ Has the client been arrested in the past six months? : Yes No If Yes, How many times? _____

☐ Is the client a veteran? : Yes No

☐ Currently enrolled in educational program? Yes No Highest Grade Completed _____

School Name : _____

☐ Employment Status: _____Employer _____

Preferred day/time of appointment:

Other Preferences:

Suicide Risk: _____ Danger to Self or Others: ___Urgent/Critical Medical Condition: _____

Immediate Threat(s): _____Past Psychiatric Admission(s): Yes No

Previous Outpatient Treatment: Yes No

Current Outpatient Provider: _____ Phone: _____

Treating Mental Health Therapist _____ **Phone:** _____

Treating Psychiatrist _____ **Phone:** _____

PLEASE COMPLETE FOR PRP AND TARGETED CASE MANAGEMENT REQUESTS

Activities of Daily Living	Anger/Temper/Conflict Resolution
Assertiveness/Self Esteem	Community Activity
Family/ Natural Supports	Finances
Home/Housing	Self Care Skills
Safety to Self/Others	School Performance
Sexual Issues	Social Skills/Peer Interaction
Substance Abuse Issues	Coping Skills
Trauma	Medication Compliance Skills
Vocational Skills	Leisure Skills
Work/Job Performance	Legal Issues (# of Arrests)
Money Management	Dietary/Food Preparation
Crisis Management Skills	Physical Health

Referral Source Printed Name & Institution (IF APPLICABLE)

Referral Source Signature: _____ Date: _____

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