A PERFECT START L . L . C .

REFERRAL FORM

☐ **OUTPATIENT THERAPY** ☐ **PRP**

IDENTIFYING INFORMATION: **Date of Referral:**

Consumer's Name:		**Date of Birth:**		**Age:**	
Address:		**Social Security:**		**Gender:**	☐ Male ☐ Female
City, State, Zip:		**Medical Assistance #:**			
Contact #:		**Current Grade:**			
Employment Status:	☐ **Employed** ☐ **Student** ☐ **other**	**Race/Ethnicity:**			
Marital Status:		**Language Spoken:**			
Veteran Status:		**Living Situation**	☐ **Private Residence** ☐ **Homeless** ☐ **Other:**		
Adult Contact's Name: **Phone Number:**		**Relationship:**	☐ **Parent** ☐ **Guardian** ☐ **Foster Care Provider** ☐ **Other:**		

Behavioral Diagnoses: *(ICD-IO Diagnosis Code Required)*	Diagnosis Code:		Description:	
	Diagnosis Code:		Description:	
	Diagnosis Code:		Description:	
Primary Medical Diagnoses: *(Required)*	Description:			
	Description:			
Social Elements Impacting Diagnoses: *(Required)*	☐ Educational ☐ Financial Access to Health Care ☐ Legal System/Crime ☐ Occupational ☐ Social Environment ☐ Primary Support ☐ Housing ☐ Homelessness ☐ Other Psychosocial & Environmental Issues:			

DSM V DIAGNOSES: (A minor must have an emotional disturbance which causes dysfunction and an adult must meet the medical admission requirements to qualify for PRP.)

CLINICAL INFORMATION:

Date of Last Therapy Appointment:	**Frequency of Treatment: ☐Weekly ☐ Bi-weekly ☐ Monthly**
How long has client been in outpatient therapy?	**☐ Between 1-5 months ☐ between 6-12 months ☐ more**

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Has client attended school/college in the last 3 months?	☐ **Yes**	☐ **No**
Has client been arrested in the last 30 days?	☐ **Yes**	☐ **No**
Has client been hospitalization in the last 30 days?	☐ **Yes**	☐ **No**
Is client a transition youth age consumer?	☐ **Yes**	☐ **No**
Is client an active participant in therapy?	☐ **Yes**	☐ **No**
Does client speak secondary language at home? If yes, which language?	☐ **Yes**	☐ **No**
Does the client have difficulty concentrating, remembering or making decisions?	☐ **Yes**	☐ **No**
Does the client have difficulty with mobility?	☐ **Yes**	☐ **No**

PLEASE CHECK ALL AREAS THAT ARE APPLICABLE TO INDIVIDUAL NEEDS:

☐	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 Management
☐	Vocational Skills	☐	Leisure Skills
☐	Work/Job Performance	☐	Legal Issues
☐	Money Management	☐	Dietary/Food Preparation
☐	Crisis Management Skills	☐	Physical Health
☐	Educational Support	☐	Suicidal Risk

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CLINICAL SUMMARY: *(Client's presenting problems)*

LICENSED MENTAL HEALTH PROFESSIONAL PROVIDING REFERAL:

Name & Credentials:		**Agency/Organization:**	
Email:		**Phone Number:**	
Supervisor's Name & Credentials:		**Supervisor's Email:**	
Signature: **Date:**			

PLEASE SUBMIT COMPLETED FORM TO: Aperfectstart2018@yahoo.com