C . O . A . C . H .
Counseling Outreach Advocacy Change Hope

C.O.A.C.H. Mental Health, LLC

Adult Psychiatric Rehabilitation Program Referral

Please help us to efficiently process your referral by completing this document its entirety.

Date: _____ Consumer Name: _____
SS#: _____-_____-_____ DOB: _____/_____/_____ Sex: _____ Race: _____
Street Address: _____
City: _____ State: _____ Zip: _____ County: _____
Phone : _____ Alternate Number: _____
Physical Description: _____ Highest Grade Completed: _____
Emergency Contact (Relationship to Consumer):_____
Contact's Phone: _____ Support for Client? Yes / No

Current Treatment Status

( ) Inpatient- projected release date: _____
( ) Partial Hospitalization- projected release date: _____
( ) Crisis Bed/Other crisis facility-projected release date: _____
( ) Outpatient
( )Date of most recent inpatient discharge:_____
( ) Other: _____

ICD-10 Diagnosis *(primary diagnosis must be listed below for adult clients to qualify for services)*

( ) F20.9	Schizophrenia
( ) F20.81	Schizophreniform Disorder
( ) F25.0	Schizophreniform Disorder, Bipolar Type
( ) F25.1	Schizoaffective Disorder, Depressive Type
( ) F28	Other Specified Schizophrenia Spectrum or Other Psychotic Disorder
( ) F29	Unspecified Schizophrenia Spectrum or Other Psychotic Disorder
( ) F22	Delusional Disorder
( ) F33.2	Major Depressive Disorder, Recurrent Episode, Severe
( ) F33.3	Major Depressive Disorder, Recurrent Episode, Severe with Psychotic Features
( ) F31.13	Bipolar I Disorder, Current or most Recent Episode Manic, Severe
( ) F31.2	Bipolar I Disorder, Current or most Recent Episode Manic, Severe, with Psychotic Features
( ) F31.4	Bipolar I Disorder, Current or most Recent Episode Depressed, Severe
( ) F31.5	Bipolar I Disorder, Current or most Recent Episode Depressed, Severe with Psychotic Features
( ) F31.0	Bipolar I Disorder, Current or most Recent Episode Hypomanic
( ) F31.9	Bipolar I Disorder, Unspecified
( ) F31.81	Bipolar II Disorder
( ) F21	Schizotypal Personality Disorder
( ) F60.3	Borderline Personality Disorder

Additional Behavioral Health Diagnosis: _____
Primary Medical Diagnosis: _____

Social Elements Impacting Diagnosis (check all that apply):

( ) None
( ) Problems with access to health care services
( ) Housing problems (Not Homelessness)
( ) Problems related to social environment
( ) Educational problems
( ) Occupational problems
( ) Problems related to interaction w/legal system/crime
( ) Homelessness o Financial problems
( ) Problems with primary support group
( ) Other psychosocial and environmental problems
( ) Unknown

Presenting Problem/Current Symptoms
(attach most recent psychosocial assessment/evaluation if available):

_____
_____

Reason(s) for referral

( ) Linkage to community resources/community integration
( ) Facilitating transition from more intensive services
( ) Prevention/reduction of hospitalization or rehospitalization
( ) Coordination of current community services
( ) Other: _____

Risk Assessment-Aggression, Homicide or Suicide(explain): _____
_____

Entitlement Information

SSI Monthly: $_____ Date Active: _____
SSDI Monthly: $_____ Date Active: _____
Medicaid Number: _____ Date Applied or Active: _____
Other Income/Insurance: _____

If consumer does NOT have medical assistance/Medicaid, he or she must meet one or more of the following criteria to qualify for services through Uninsured Eligibility Coverage:

( ) Currently homeless or at risk for homelessness
( ) Has had an inpatient hospitalization within the last three (3) months
( ) Has been incarcerated within the last three (3) months

Upon the clinician's signature below, the consumer being referred is appropriate for psychiatric rehabilitation program services provided by C.O.A.C.H. Mental Health, LLC. ***This referral must be signed by a physician, nurse practitioner, or independently licensed clinician (LCSW-C or LCPC.)***

I, _____, refer_____
(Print Clinician's Name & Credentials) (Print Consumer's Name)

_____ _____
(Clinician's Signature) (Clinician's Phone Number)

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