***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  Male  Female  Transgender 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)

***5 Shawan Road, Suite 101-C,Hunt Valley, MD 21030***

***Phone: (443)982-0692, Fax: (443)982-0610/Website: www.coachmentalhealth.com***