***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***