***Child & Adolescent 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:

School:       Current Grade:

School Services:

IEP  504  Other:

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:**      

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 (Check all that apply):**

Self-Care Skills

Social Skills

Independent Living Skills

Conflict Resolution

Anger Management

Interactive Skills with Peers and Authority Figures

Maintaining Personal Living Space

Maintaining Personal Safety in Social Environments

Time Management

Other

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

**Involvement Information:**  DJS  DSS

Medicaid Number:       Date Applied or Active:

Other Income/Insurance:

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***