***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***

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