**4 2 RESTORE, LLC**

**PSYCHIATRIC REHABILITATION PROGRAM REFERRAL**

**ADULTS**

|  |  |
| --- | --- |
| **CONSUMER INFORMATION** [ ]  INITIAL [ ]  RE-REFERAL **DATE:** 09/22/23 |  |
| **Name** |  | **DOB** |  | **Age** |  |
| **Address** |  | **City, State, Zip** |  |
| **Phone #** |  | **Medicaid #** |  |
| **Sexual****Orientation** | **[ ]  Heterosexual** **[ ]  Gay/Lesbian** **[ ]  Bisexual** **[ ]  Don’t know** **[ ]  Decline****[ ]  Something Else, Please Describe:**  |
| **Gender****Identification** | **[ ]  Male** **[ ]  Female** **[ ]  Transgender Male/Trans Man (F to M)****[ ]  Transgender Female/Trans Woman (M to F)****[ ]  Gender Queer (or Gender non-conforming)****[ ]  Additional Gender Category, please specify:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**[ ]  Decline** |
| **Race/Ethnicity** | **[ ]  African American** **[ ]  Asian** **[ ]  Hispanic** **[ ]  Non-Hispanic** **[ ]  White** **[ ]  Amer. Indian/Alaskan Native** **[ ]  Native Amer./Hawaiian or Other Pacific** |
| **Access to Transportation for onsite activities** | **[ ]  Yes** **[ ]  No** |

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| --- |
| **REFERRAL SOURCE INFORMATION**  |
| **Name of Referring Person** |  |
| **Name of Referring Agency** |  |
| **Address:** |  |
| **City, State, Zip Code** |  |

|  |  |
| --- | --- |
| **CATEGORY A** | **CATEGORY B** |
| [ ]  F20.9 Schizophrenia, Unspecified | [ ]  F31.0 Bipolar I Disorder, Hypomanic |
| [ ]  F20.81 Schizophreniform Disorder | [ ]  F31.13 Bipolar Disorder, Manic, Severe |
| [ ]  F22 Delusional Disorder | [ ]  F31.4 Bipolar I Disorder, Depressed, Severe |
| [ ]  F25.0 Schizoaffective Disorder, Bipolar Type | [ ]  F31.81 Bipolar II Disorder |
| [ ]  F25.1 Schizoaffective Disorder, Depressive | [ ]  F31.9 Bipolar Disorder, Hypomanic, Unspecified |
| [ ]  F28 Other Specified Schizophrenia Spectrum & Other Psychotic Disorder | [ ]  F33.2 MDD, Recurrent, Severe, w/o Psychotic Features |
| [ ]  F29 Unspecified Schizophrenia Spectrum & Other Psychotic Disorder | [ ]  60.3 Borderline Personality Disorder |
| [ ]  F31.2 Bipolar I D/O, Manic Severe w/Psychotic Features |  |
| [ ]  F31.5 Bipolar I D/O, Depressed, Severe w/Psychotic Features |  |
| [ ]  F33.3 MDD, Recurrent, Severe w/Psychotic Features |  |

Does the client have SSI/SSDI? [ ]  Yes [ ]  No, please see attached.

|  |  |
| --- | --- |
| **Medication** | **Dosage/Frequency** |
|  |  |
|  |  |
|  |  |
|  |  |
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**CLINCAL INFORMATION**

1. Why is ongoing outpatient treatment not sufficient to address concerns?
2. Is the participant receiving outpatient mental health services? [ ]  Yes [ ]  No
3. Is the licensed mental health provider enrolled as a provider in the Medicaid Program? [ ]  Yes [ ]  No
4. Has an Individual Treatment Plan/Individualized Rehabilitation Plan been completed? [ ]  Yes [ ]  No
5. Is individual currently receiving mental health treatment from a licensed mental health professional?

[ ]  Yes [ ]  No, ***if Yes and is a LMSW or LGPC, please provide Supervisors name:***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. ***If a LCSW-C or LCPC-C, must with your governing Board.***

1. Is this person, in some way, paid by the PRP program of receives other benefits from the PRP program? [ ]  Yes [ ]  No
2. Duration of current episode of treatment provided to this individual:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  < 1 month | [ ]  1-3 months | [ ]  4-6 months | [ ]  7-12 months  | [ ]  12 months > |

1. Current frequency of treatment provided to this individual:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  < 1x/ week | [ ]  1x/2 weeks | [ ]  1x/ month | [ ]  1x/3 months | [ ]  1x/ 6 months |

1. Has this individual received PRP services from at least 1 other PRP with in the past year? [ ]  Yes [ ]  No

**Please indicate which of the following program(s) the individual is also receiving services from:**

1. Mobile Treatment/Assertive Community Treatment (ACT) [ ]  N/A [ ]  Currently [ ]  In the past 30-days
2. Inpatient Psychiatric Treatment [ ]  N/A [ ]  Currently [ ]  In the past 30-days
3. Residential SUD Treatment 3.3 [ ]  N/A [ ]  Currently [ ]  In the past 30-days
4. Residential SUD Treatment 3.5 [ ]  N/A [ ]  Currently [ ]  In the past 30-days
5. Residential SUD Treatment 3.7 [ ]  N/A [ ]  Currently [ ]  In the past 30-days
6. Mental Health Intensive Outpatient Program (IOP) [ ]  N/A [ ]  Currently [ ]  In the past 30-days
7. Mental Health Partial Hospital Program [ ]  N/A [ ]  Currently [ ]  In the past 30-days
8. SUD Intensive Outpatient Program (IOP) Level 2.1 [ ]  N/A [ ]  Currently [ ]  In the past 30-days
9. SUD Partial Hospitalization (PHP) Level 2.2 [ ]  N/A [ ]  Currently [ ]  In the past 30-days
10. Residential Crisis [ ]  N/A [ ]  Currently [ ]  In the past 30-days
11. If currently in treatment in one of the services listed above, a written Treatment Plan will be attached to this request.

**FUNCTIONAL CRITERIA**

***Per medical necessity criteria, at least 3 of the following must have been present on a continuing or intermittent basis over the past 2 years. Functional Impairment(s): (If Yes, explain).***

**Example:**

**To understand what is being requested for each of the Functional Impairments below, a generalized example of a response is provided here:**

1. **Symptoms of Priority Population diagnosis: Paranoia**
2. **Impairment impacting Functioning: Paranoia results in being suspicious of others.**
3. **Example of impaired function: Last week he would not get on the bus because hr thought the driver was out to get him. He started yelling at the bus driver.**

**If your answer is “Yes” to the questions below, please answer the question functional criteria.**

[ ]  Yes [ ]  No Marked inability to establish or maintain competitive employment.

**Describe the symptoms of this Priority Population diagnosis that affect the participant’s function.**

**Describe how, specifically, these symptoms impair the participant's functioning.**

**Provide specific concrete examples of THIS participant’s function.**

[ ]  Yes [ ]  No Marked inability to perform instrumental activities of daily living (eg: shopping, meal preparation, laundry, basic housekeeping, medication management, and money management).

**Describe the symptoms of this Priority Population diagnosis that affect the participant’s function.**

**Describe how, specifically, these symptoms impair the participant's functioning.**

**Provide specific concrete examples of THIS participant’s function.**

[ ]  Yes [ ]  No Marked inability to establish/maintain a personal system.

**Describe the symptoms of this Priority Population diagnosis that affect the participant’s function.**

**Describe how, specifically, these symptoms impair the participant's functioning.**

**Provide specific concrete examples of THIS participant’s function.**

[ ]  Yes [ ]  No Deficiencies of concentration/persistence/pace leading to failure to complete tasks.

**Describe the symptoms of this Priority Population diagnosis that affect the participant’s function.**

**Describe how, specifically, these symptoms impair the participant's functioning.**

**Provide specific concrete examples of THIS participant’s function.**

[ ]  Yes [ ]  No Unable to perform self-care (hygenie, grooming, nutrition, medical care, safety).

**Describe the symptoms of this Priority Population diagnosis that affect the participant’s function.**

**Describe how, specifically, these symptoms impair the participant's functioning.**

**Provide specific concrete examples of THIS participant’s function.**

[ ]  Yes [ ]  No Marked deficiencies in self-direction, shown by inability to plan, initiate, organize and carry out goal directed activities.

**Describe the symptoms of this Priority Population diagnosis that affect the participant’s function.**

**Describe how, specifically, these symptoms impair the participant's functioning.**

**Provide specific concrete examples of THIS participant’s function.**

[ ]  Yes [ ]  No Marked inability to procure financial assistance to support community living.

**Describe the symptoms of this Priority Population diagnosis that affect the participant’s function.**

**Describe how, specifically, these symptoms impair the participant's functioning.**

**Provide specific concrete examples of THIS participant’s function.**

**DURATION OF IMPAIRMENT(S)**

Marked functional impairment has been present for less than 2 years. [ ]  Yes [ ]  No

Has demonstrated marked improved functioning primarily due in a mental illness in at least 3 of the areas listed above at least 2 years. [ ]  Yes [ ]  No

**Why is ongoing outpatient treatment not sufficient to address concerns?**

**CRIMINAL HISTORY:** **[ ]** Yes [ ]  No

**REASON FOR REFERRAL:** *(Indicate the areas you want PRP to address)*

1. **Self-Care Skills:** [ ]  Personal Hygiene [ ]  Grooming [ ]  Nutrition [ ]  Dietary Planning

**[ ]** Food Preparation [ ]  Self-Administration of Medication

1. **Social Skills:** [ ]  Community Integration Activities [ ]  Developing Natural Support

 [ ]  Developing linkages with and Supporting the Individual’s Participation in

 Community Activities

1. **Independent Living Skills:** [ ]  Skills Necessary for Housing Stability [ ]  Community Awareness

 [ ]  Mobility & Transportation Skills [ ]  Money Management

 [ ]  Accessing Available Entitlement & Resources

 [ ]  Supporting the Individual to Obtain & Retain Employment.

 [ ]  Health Promotion & Training

 [ ]  Individual Wellness Self-Management & Recovery

**MENTAL HEALTH PRACTITIONER:**

|  |  |
| --- | --- |
| Name: | Date: |
| Signature: |  |

|  |
| --- |
| ***Attach a copy of the current Treatment Plan.*** |

***PRP Staff:*** Date Referral, Assertion of Need & Tx Plan Received \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Screening Scheduled within 5 days? [ ]  Yes [ ]  No