**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** | | | | | |

|  |  |
| --- | --- |
| **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