August Rose Health Center

Adult PRP Referral

Name		**DOB**	/ /	**Gender**		**Race**	
Address							
Phone number		**Additional**					
Insurance #		**Marital Status**		**Native Language**			
Legal Guardian							

Referral Source

Name		**Affiliated Clinic**	
Address			
Phone Number		**Fax:**	**Email address**

How long has this client been in services with you?		**How often do you meet with client?**	○ Weekly ○ Biweekly ○ Monthly ○ Other

Substance Abuse History	**Yes Or No**	*If Yes, Indicate Substance(s) of choice:*
Suicidal	**Yes Or No**	*If Yes, Indicate history:*
Homicidal	**Yes Or No**	*If Yes, Indicate hist*

Qualifying Adult Diagnosis

(Must be at least one of the following)

Category A Diagnosis- Must meet either criteria 1 or 2 under "Additional Service Criteria Requirements" listed below

- ☐ F20.81 Schizophreniform Disorder
- ☐ F20.9 Schizophrenia
- ☐ F22 Delusional Disorder
- ☐ F25.0 Schizoaffective Disorder, Bipolar Type
- ☐ F25.1 Schizoaffective Disorder, Depressive Type
- ☐ F29 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
- ☐ F31.2 Bipolar I Disorder, Current or MRE Manic, /w Psychotic Features
- ☐ F31.5 Bipolar I disorder, Current or MRE Depressed, /w Psychotic Features
- ☐ F33.3 MDD, Recurrent Episode, /w Psychotic Features
- ☐ F28 Other Specified Schizophrenia Spectrum and other Psychotic Disorder

Category B Diagnosis- Must meet criteria #2 under "Additional Service Criteria Requirements" listed below.

- ☐ F31 Bipolar I Disorder, Current or most recent episode Hypomanic
- ☐ F31.13 Bipolar I Disorder, Current or Most recent episode Manic, Severe
- ☐ F31.4 Bipolar I Disorder, Current or most recent episode Depressed, Severe
- ☐ F31.81 Bipolar II Disorder, Unspecified
- ☐ F31.9 Unspecified Bipolar and Related Disorder
- ☐ F33.2 Major Depressive Disorder, Recurrent Episode, Severe
- ☐ F60.3 Borderline Personality Disorder
- ☐ _____

Additional Service Criteria Requirements

Please check all that apply

7477 Baltimore Annapolis Road Suite 201
Glen Burnie, MD 21061
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☐ The individual is enrolled in SSI or SSDI

☐ The referred individual demonstrates impaired functioning for at least two years as evidenced by at least 3 of the following criteria on a continuing or intermittent basis. Please include specifics

- ☐ Marked inability to establish or maintain independent competitive employment
- ☐ Marked inability to perform instrumental activities of daily living (Shopping, meal prep, household chores, med management, transportation, money management)
- ☐ Marked inability to establish or maintain personal support system
- ☐ Marked or frequent deficiencies of concentration, persistence, or pace
- ☐ Marked inability to perform or maintain self-care (hygiene, grooming, nutrition, medical care, personal safety)
- ☐ Marked deficiencies in self-direction
- ☐ Marked inability to procure financial assistance to support community living

☐ Individual doesn't have two years of impaired functioning as required for a category B diagnosis, but they have a new onset category A diagnosis and PRP services are the most effective means to diminish risk.

Requested Services (Check all that apply)

Self-Care Skills	Social Skills	Independent Living Skills	Community Resources Coordination	Symptom Management
○ Hygiene ○ Nutrition ○ Physical Health ○ Personal safety	○ Developing supports ○ Conflict resolution ○ Boundary awareness ○ Communication skills	○ Money management ○ Maintaining living env't ○ Cooking/Shopping ○ Time management	○ Identifying resources ○ Entitlement Application ○ Housing Coordination ○ Vocational/Job Skill	○ Psychoeducation ○ Coping skill development ○ Mental health education ○ Emotional Regulation

Print Name and Credentials		**Date of referral**	
Signature		**Phone number**	

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