DIVINE PURPOSE
COMMUNITY SERVICES LLC

Child and Adolescent Psychiatric Rehabilitation Program Referral Form

Client Name: _____ MA#: _____

Parent/Legal Guardian Name: _____

Address: _____

Phone #: _____ Alternate phone #: _____

DOB: _____ Sex/Gender: _____

This form must be filled out in its entirety in order to allow for medical necessity and authorization for services.

Behavioral Diagnoses: _____

Medical Diagnoses: _____

Social Elements Impacting Diagnoses: (Check all the apply)
___ None ___ Educational ___Financial ___ Problems with access to healthcare services ___ Primary support group
___Problems related to interactions with legal system/crime ___ Housing problems (not homelessness) ___ Occupational Problems
___Problems related to the social environment ___ Homeless ___ Unknown
___Other psychosocial and environmental problems Please specify: _____

Diagnosis Source: _____

Admission Criteria- Please verify that all of the following admission Criteria is met.

a. **Client has a PMHS specialty mental health diagnosis and the individual's impairment(s) and functional behavior is expected to improve with these services**
b. **The individual's mental illness is the cause of serious dysfunction in one or more life domains (home, school, community)**
c. **The impairment as a result of the individual's mental illness results in:**
   A clear, current threat to the individual's ability to be maintained in his/her customary setting, or
   An emerging/pending risk to the safety of the Individual and others, or
   Other evidence of significant psychological or social impairments such as inappropriate social Behavior causing serious problems with peer relationships and/or family members.
d. **The Individual, due to the dysfunction, is at risk for requiring a higher level of care, or is returning from a higher level of care.**
e. **The Individual's condition requires an integrated program of rehabilitation services to develop and restore independent living skills to support the Individual's recovery.**
f. **The Individual does not require a more intensive level of care and is judged to be in enough behavioral control to be safe in the rehabilitation program and benefit from the rehabilitation provided.**
g. **A documented crisis response plan for the Individual is in progress or completed.**
h. **An Individual Rehabilitation Plan (IRP) is in progress or completed.**
i. **PRP services will be rendered by staff that is supervised by a licensed mental health professional.**

DPCS LLC
1330 Smith Avenue
Baltimore, MD 21209
(410)805-1070
www.divinepurposecs.com

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And either:

There is clinical evidence that the current intensity of outpatient treatment will not be sufficient to reduce the individual's symptoms and functional behavioral impairment resulting from the mental illness and restore him/her to an appropriate functional level, or prevent clinical deterioration, or prevent the need to initiate a more intensive level of care due to current risk to the Individual or others; or

For Individual transitioning from an inpatient, day hospital or residential treatment setting to a community setting there is clinical evidence that PRP services will be necessary to prevent clinical deterioration and support successful transition back to the community, or prevent the need to initiate or continue a more intensive level of care.

Current Medications: _____

Presenting Symptoms: Please include hx of SI and HI and/or judicial involvement including Child Protective Services.

_____

_____

_____

Reason for Referral: What types of goals should be the focus of intervention:

_____

_____

_____

_____

Please attach the following: current med sheet and ITP. Thanks

_____

Printed Name and Credentials

_____

Referring Clinician's e-mail and Contact Number

_____

Signature

_____

Date

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