NEW VISION BEHAVIORAL HEALTH SERVICES INC, PRP
"New Path. New Vision"
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Ph.# 410-254-4343 Fax# 410-254-4342

CHILD AND ADOLESCENT PRP REFERRAL FORM

Check One:
[] Initial Referral [] Concurrent Referral

Date:

Name:	D.O.B:	Age:	Gender:		Social Sec#:
Address:	City		State:	Zip Code:	Phone:
Medicaid#:					

Guardianship: Attach court order if applicable.

Legal Guardian:_____Relationship:_____Phone #_____

PRP-CRITERIA FOR CHILDREN/YOUTH.

DSM-V Diagnosis:

Please check below:

	Transitioning from inpatient, day hospital or residential treatment setting		Currently engaging in Medication Management services.

Functional Impairment(s)

Check all that apply:

	A clear, current threat to the individual's ability to be maintained in his/her customary setting?
	An emerging risk to the safety of the youth or others?
	Significant psychological or social impairments such as inappropriate social behavior causing serious problems with peer relationships and family members?
	Currently engaged in ongoing outpatient treatment to reduce youth's symptoms and functional behavioral impairment resulting fro Mental illness?

Check all that apply:

	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
	The individual's condition requires an integrated program of rehabilitation services to develop and restore independent living Skills to support the individual's recovery
	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 services provided.

Minor/Youth-Services Needed:

Age-appropriate self -care skills:[] Personal Hygiene [] Grooming [] Nutrition [] Dietary planning [] Food preparation [] Self administration of medication [] Medication monitoring

Social Skills:[] Community integration activities [] Developing natural support [] Developing linkages with and supporting the minor's participation in community activities.

Name: D.O.B

Independent Living Skills:[] Maintenance of the minor's living environment [] Community awareness [] Mobility skills
[] Money management [] Accessing available entitlement.**[]** Activities that support the minor's cultural interest [] Conflict resolution.
[] Anger management [] Interactive skills with peers and authority figures [] Maintaining age-appropriate boundaries
[] Maintaining personal safety in a social environment [] Time management[] Improving Academic Performance [] Other

Referring MH Professional Signature:_____Credentials:_____Date:_____

Referring MH Professional Printed Name:_____

Supervisor'sName:_____Credentials:_____
(If, applicable)

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Is individual appropriate for PRP services [] Yes [] No reason_____

If no was parent informed: [] Yes [] No