PRP Referral Form

Patient Name: ____

DOB: _______/_______/_______ Sex: _____________ Race: ___________________

Street Address: ____

City: __________________________________ State: ______ Zip: ____________ County: _________________________

Phone (Home): ___________________________________(Work/Mobile):____

Highest Grade Completed: ____

Emergency Contact (Relationship to Patient):__________________________ ____

Contact's Phone (Home): _______________________(Work/Mobile): _______________________ Support for Patient? Yes / No

Current Patient Status (please indicate to assist in the prioritization of referrals):

- ☐ Inpatient- projected release date: ____
- ☐ Partial Hospitalization- projected release date: _______________________________
- ☐ Crisis Bed/Other crisis facility- projected release date: ________________________
- ☐ Outpatient
- ☐ Date of most recent inpatient discharge: ____________________________________
- ☐ Other: ____

DSM 5 Behavioral Diagnoses: DSM-5 / ICD-10 Behavioral Diagnosis: (Patient must have one of these diagnoses as primary)

- ☐ 295.90/F20.9 Schizophrenia
- ☐ 295.40/F20.81 Schizophreniform Disorder
- ☐ 295.70/F25.0 Schizoaffective Disorder, Bipolar Type
- ☐ 295.70/F25.1 Schizoaffective Disorder, Depressive Type
- ☐ 298.8/F28 Other Specified Schizophrenia Spectrum or Other Psychotic Disorder
- ☐ 298.9/F29 Unspecified Schizophrenia Spectrum of Other Psychotic Disorder
- ☐ 297.1/F22 Delusional Disorder
- ☐ 296.33/F33.2 Major Depressive Disorder, Recurrent Episode, Severe
- ☐ 296.34/F33.3 Major Depressive Disorder, Recurrent Episode, Severe with Psychotic Features
- ☐ 296.43/F31.13 Bipolar I Disorder, Current or most Recent Episode Manic, Severe
- ☐ 296.44/F31.2 Bipolar I Disorder, Current or most Recent Episode Manic, Severe, with Psychotic Features
- ☐ 296.53/F31.4 Bipolar I Disorder, Current or most Recent Episode Depressed, Severe
- ☐ 296.54/F31.5 Bipolar I Disorder, Current or most Recent Episode Depressed, Severe with Psychotic Features
- ☐ 296.40/F31.0 Bipolar I Disorder, Current or most Recent Episode Hypomanic
- ☐ 296.7/F31.9 Bipolar I Disorder, Unspecified
- ☐ 296.89/F31.81 Bipolar II Disorder,
- ☐ 301.22/F21 Schizotypal Personality Disorder
- ☐ 301.83/F60.3 Borderline Personality Disorder

In order to qualify for PRP program, patient must meet the target diagnostic criteria and meet the following functional limitations:
Serious mental illness is characterized by impaired role functioning, on a continuing or intermittent basis for at least two years including at least there (3) of the following:

☐ Social Elements Impacting Diagnosis ☐ Problems with access to health care Service ☐ Housing Problems (Not Homelessness) ☐ Problems with primary support group ☐ Educational Problems ☐ Problems Related to Interaction W/Legal Systems/ Crime	☐ Homelessness ☐ Problems related to the Social Environment ☐ Occupational Problems ☐ Other Psychosocial and Environment Problems ☐ Medical disabilities that impact diagnosis or must be accommodated for in treatment

Client would benefit with assistance in developing the following skills to be successful in their recovery:

___Activities of Daily Living __ Safety to Self/Others __ Vocational Skills

__ Anger/Temper/Conflict Resolution __ School Performance __ Leisure Skills

__ Assertiveness/Self-esteem __ Sexual Issues __ Work/Job Performance

__ Community Activity __ Social Interaction Skills __ Legal Issues

__ Family/Natural Supports __ Substance Abuse Issues __ Money Management

__ Finances/Budgeting __ Coping Skills __ Dietary/Food Preparation

__ Home/Housing __ Trauma __ Crisis Management Skills

__ Self Care Skills __ Medication Compliance Skills

_Client Name_____ diagnosis has created difficulty in their ability develop or restore their independent living and social skills. Please note the following functional impairments:

__ Inability to maintain independent employment

__ Social behavior that results in interventions by the mental health system

__ Severely impaired concentration or thought organization

__ Inability to obtain financial assistance to support living in the community

__ Severe inability to establish or maintain a personal support system

__ Need for assistance with basic living skills

__ An inability to manage the effects of his/her mental illness

__ Less treatment was insufficient in preventing deterioration and requires stabilization

Please note the clients support system as follows:
____

Upon the clinician’s signature below, the Patient being referred is appropriate for psychiatric rehabilitation program
services provided by Behavioral Health Clinic (BHC). This referral must be signed by a physician, nurse practitioner, or
licensed behavioral health clinician.

I, ____,
refer____

(Clinician's Signature) (Print Patient's Name)

____
____

(Print Clinician's Name and Credentials) (Clinician's Phone Number)