REFERRAL TO: BEHAVIORAL HEALTH & LEADERSHIP DYNAMICS, LLC (BHLD)
PSYCHIATRIC REHABILITATON PROGRAM (PRP) -ADULTS
5209 York Road, Baltimore, MD 21212
Phone: 443-438-8082
Use DocuSign to Digitally Sign and Send Form or FAX TO: 410-630-1021

CLIENT INFORMATION Please enter "n/a" for any question that does not apply to the client			
Client's Name:	Alias Names:	Parent/ Guardian Name:	
Gender: ⓘ ☐ M ☐ F	Gender Description (Optional) ⓘ	Race:	
DOB:	SSN:	Medicaid/Insurance #: Effective Dates	
Partner or Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ N/A ☐ Separated ☐ Widowed		Name of Spouse: Name of Partner:	Phone: Phone:
Street Address:		Home Phone:	
City, State Zip		Cell Phone:	
Best Times to Contact Client / Parent or Guardian: Days Hours		Email:	

REFERRING PROVIDER/AGENCY INFORMATION		
Provider Agency		Name of Provider
Address of Agency:		Licensure of Provider
City, State, Zip		Is Provider willing to review and give input into the PRP Rehabilitation Plan? ☐ Yes ☐ No
Phone:	Fax:	
Date Referral Form Submitted to BHLD:		Client Release of Information Form Signed/Attached: ☐ Yes ☐ No
Digitally Sign this form on the last page		Best Times to Contact Provider: Days Hours

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EMERGENCY CONTACT INFORMATION				
Name	Relationship	Phone	Email	Address

HOUSING INFORMATION:	
Client's Housing	☐ Apt. ☐ Private Home ☐ Residential Housing ☐ Other:
Client Lives in the Residence of:	☐ Significant Other /Partner ☐ Neighbor(s) ☐ Alone ☐ Parent/Family ☐ Friend(s) ☐ Other:
Who does client live with? Include pets and/or children in the home. **Specify relationship.**	

VOCATIONAL /EMPLOYMENT INFORMATION	
Highest Level of Education	**Veteran** ☐ No ☐ Yes, Branch of Service
Employment Status ☐ Student ☐ Employed Full Time ☐ Employed Part Time ☐ Irregular/ Contractual ☐ Unemployed	
If Employed Type of Job	**Duration of Employment**
Place of Employment	
If unemployed or employed irregularly, is client willing to work? ☐ N/A ☐ Yes ☐ No	Needs Job Readiness skills: ☐ Yes ☐ No
	Needs Coping Skills: ☐ Yes ☐ No
	Needs Vocational Skills / Additional Education: ☐ Yes ☐ No
	Needs Symptom Management: ☐ Yes ☐ No
Does Client Currently Volunteer? ☐ Yes ☐ No	Duties
	Organization

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INCOME/ENTITLEMENTS AND AMOUNT ☐ Check box if information is not available (Check all that apply, enter amount if known)		
SSI: ☐	**Wages:** ☐	**VA Benefits:** ☐
SSDI: ☐	**Rental Assistance:** ☐	**Other (Specify):**
WIC: ☐	**Social Security:** ☐	**Other (Specify):**
Food Stamps: ☐	**TEMHA(***Temp Emergency Medical & Housing Assis***):** ☐	

REASON FOR REFERRAL TO BHLD'S PRP:

Recommending: ☐ **Both Onsite & Offsite (Check indicates your understanding that BHLD PRP may provide a mix of onsite and offsite services depending upon client needs and preferences.)**

CONFLICTING SERVICES WITH PRP LISTED BELOW (Per Medicaid)	
Client currently receiving other PRP services: ☐ Yes ☐ No ☐ Uncertain	If Yes Specify:
Client currently receiving Mobile Treatment Services: ☐ Yes ☐ No ☐ Uncertain	If Yes Specify:
Client currently receiving Case Management Services: ☐ Yes ☐ No ☐ Uncertain	If Yes Specify:

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RISK/DANGEROUSNESS TO SELF OR OTHERS AND CRIMINAL BACKGROUND (Check all that apply)			
Suicidal Behavior:	☐ Denies	☐ History	Current - Specify ☐
Aggressiveness:	☐ Denies	☐ History	Current - Specify ☐
Substance Abuse:	☐ Denies	☐ History	Current - Specify ☐
Physical or Sexual Abuse (Perpetrator)	☐ Denies	☐ History	Current - Specify ☐
Criminal/Legal	☐ Denies	☐ History	Current - Specify ☐
Currently on Parole/Probation	☐ No	☐ Yes, Specify Reason	
Name of Officer	Name		Phone

HISTORY OF INPATIENT PSYCHIATRIC HOSPITALIZATION

☐ Check box if this does not apply

1)Hospital:	**Adm. Date:**	**D/C Date:**
2)		
3)		
4)		

HISTORY OF PARTIAL HOSPITALIZATION (PHP)

☐ Check box if this does not apply

1)Hospital:	**Adm. Date:**	**D/C Date:**
2)		
3)		
4)		

Additional Comments:

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<table>
<tr><td colspan="4">CURRENT MENTAL HEALTH OR SUBSTANCE ABUSE TREATMENT/ SERVICES (please list Current treatment only)</td></tr>
<tr><td>Outpatient Mental Health Counseling / Psychotherapy:
☐ Yes ☐ No</td><td colspan="2">If Yes, Date of First Counseling Session</td><td>Is Client Actively Participating in Counseling?
☐ Yes ☐ No</td></tr>
<tr><td rowspan="2">Substance Abuse Treatment:
☐ Yes ☐ No</td><td>If Yes, Date of Admission</td><td rowspan="2">Name of Facility</td><td>Contact at Facility</td></tr>
<tr><td>Tentative Discharge Date</td><td>Phone</td></tr>
<tr><td rowspan="2">Inpatient Psychiatric Treatment:
☐ Yes ☐ No</td><td>If Yes, Date of Admission</td><td rowspan="2">Name of Facility</td><td>Contact at Facility</td></tr>
<tr><td>Tentative Discharge Date</td><td>Phone</td></tr>
<tr><td rowspan="2">Residential Treatment Center:
☐ Yes ☐ No</td><td>If Yes, Date of Admission</td><td rowspan="2">Name of Facility</td><td>Contact at Facility</td></tr>
<tr><td>Tentative Discharge Date</td><td>Phone</td></tr>
<tr><td rowspan="2">Other Treatment:
☐ Yes ☐ No</td><td>If Yes, Date of Admission</td><td rowspan="2">Name of Facility</td><td>Contact at Facility</td></tr>
<tr><td>Tentative Discharge Date</td><td>Phone</td></tr>
</table>

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MEDICAL INFORMATION

(List significant medical problems including seizure disorders)

☐ Check box if client has no medical concerns at this time

Medical Diagnosis/Health Concern & Date of Onset	Treating Medical Professional / Phone	Treatment (List Prescribed Medications Chart below)
	Name Phone	
	Name Phone	
	Name Phone	
	Name Phone	
	Name Phone	
	Name Phone	

MEDICATIONS PRESCRIBED:

☐ Check box if client does not take any meds at this time

Medication/ Date Prescribed	Purpose	Who Prescribed	Strength	Dosage	Side Effects	Benefits	Compliant Yes; No

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PRIORITY POPULATION DIAGNOSES AND ADMITTING CRITERIA
Check the Appropriate Diagnoses and ICD-9 and ICD-10 Diagnoses Codes

Check Applicable	**DSM-5 Diagnoses**	***ICD-9 and ICD-10 Diagnoses Codes***
☐	Schizophrenia	295.90/ F20.9
☐	Schizophreniform Disorder	295.40/F20.81
☐	Schizoaffective Disorder, Bipolar Type	295.70/F25.0
☐	Schizoaffective Disorder, Depressive Type	295.70/F25.1
☐	Other Specified Schizophrenia Spectrum and Other Psychotic Disorder	298.8/F28
☐	Unspecified Schizophrenia Spectrum and Other Psychotic Disorder	298.9/F29
☐	Delusional Disorder	297.1/F22
☐		
☐	Major Depressive Disorder, Recurrent Episode, Severe	296.33/F33.2
☐	Major Depressive Disorder, Recurrent Episode, with Psychotic Features	296.34/F33.3
☐		
☐	Bipolar I Disorder, Current or Most Recent Episode Manic, Severe	296.43/F31.13
☐	Bipolar I Disorder, Current or Most Recent Episode Manic, with Psychotic Features	296.44/F31.2
☐	Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe	296.53/F31.4
☐	Bipolar I Disorder, Most Recent Episode Depressed, With Psychotic Features	296.54/F31.5
☐	Bipolar I Disorder, Current or Most Recent Episode Hypomanic	296.40/F31.0
☐	Bipolar I Disorder, Current or Most Recent Episode Hypomanic, Unspecified	296.40/F31.9
☐	Bipolar I Disorder, Current or Most Recent Episode, Unspecified	296.7/F31.9
☐	Unspecified Bipolar and Related Disorder	296.80/F31.9
☐	Bipolar II Disorder	296.89/F31.81
☐		
☐	Schizotypal Personality Disorder	301.22/F21
☐	Borderline Personality Disorder	301.83/F60.3

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FUNCTIONAL LIMITATIONS **I have Reviewed the Following Functional Limitations Criteria:** ☐ Yes ☐ No Serious Mental Illness is characterized by impaired role functioning on a continuing or intermittent basis, for at least two years and including at least three of the following:	
Criteria	
Inability to Maintain Independent Employment	
Social Behavior that Results in Interventions by the Mental Health System	
Inability, due to Cognitive Disorganization, to Procure 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	

ADMISSION CRITERIA ****ALL 7 of the following criteria are necessary for admission to PRP**** **I have Reviewed the Following Admission Criteria:** ☑ **Yes** ☐ **No**	
1. The participant has a PBHS specialty mental health DSM 5 diagnosis included in the priority population as seen on page 7 above and the participant's impairment(s) can be expected to be stabilized at this level of care.	
2. The impairment results in at least ONE of the following:	
a. A clear, current threat to the participant's ability to live in his/her customary setting.	
b. An inability to be employed or attend school without support	
c. An inability to manage the effects of his/her mental illness	
3. The participant's condition requires an integrated program of rehabilitation services to develop and restore independent living skills to support the participant's recovery.	
4. The participant must be concurrently engaged in outpatient mental health treatment.	
5. All participants residing in a RRP must have PRP services available.	
6. The participant does not require a more intensive level of care.	
7. All less intensive levels of treatment have been determined to be unsafe or unsuccessful.	

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RECOMMANDATIONS TO CONSIDER IN COLLABORATION WITH CLIENT AND/OR GUARDIAN With client consent, client may benefit from these BHLD Services	
BHLD PRP does not dispense nor oversee management of client medications.	☐ ACCEPTABLE
Client can benefit from both Onsite and Offsite PRP services.	☐ Yes ☐ No
Client can benefit from the use of animal-assisted support services to enhance coping skills, address client symptoms, and to enhance functioning in the community setting.	☐ Yes ☐ No
Client can benefit from Job Readiness Support.	☐ Yes ☐ No
Client can benefit from Self-Care Skills including Compliance with Medical or Therapy Appointments.	☐ Yes ☐ No

PRP Skill Building Services Client can benefit from education and support to enhance:	
Symptom Management	☐ Yes ☐ No
Coping	☐ Yes ☐ No
Job Readiness	☐ Yes ☐ No
Relationship & Social Support	☐ Yes ☐ No
Emotional Resiliency	☐ Yes ☐ No
Health/Wellness/Safety	☐ Yes ☐ No
Money Management	☐ Yes ☐ No
Locating Optimal Housing	☐ Yes ☐ No
Anger Management	☐ Yes ☐ No
Accessing Entitlements and Community Resources	☐ Yes ☐ No
Other ☐	Specify:

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SEVERITY OF NEED AND INTENSITY OF SERVICE **I have reviewed the Following Severity of Need and Intensity of Service Criteria for PRP services:** ☐ **YES** ☐ **NO** **(Checking Yes indicates that Client's severity of need and intesity of service are suitable for BHLD PRP)**
Medical necessity for admission to PRP services must be documented by the presence of all of the criteria
The length and frequency of the services varies based on the participant's needs and medical necessity. Professional and/or social supports must be identified and available to the participant outside of program hours.
And the participant must be capable of seeking them (supports) as needed.
Active involvement of the participant, family, caretakers,or significant others involved in the participant's treatment will be sought.

Additional Comments:

Note: Do Not Email this form. Private Information should be handled in a secure manner.Send in one of these two methods:

1. Use DocuSign.com to Send to Margaret McCraw at info@bhcld.com for a secure Digital Signature and encrypted storage

OR

2. Print entire document **SIGN, CREDENTIAL and DATE** printed form and FAX TO: 410-630-1021

Signature of Licensed Mental Health Professional and Credentials	Date