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

REASON FOR REFERRAL TO BHLD'S PRP:		
Recommending:	☐ **Both Onsite and 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:

CLIENT INFORMATION Please enter N/A to any questions that do not apply			
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 or Parent / Guardian: Days Hours		Email:	

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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
Best Times to Contact Provider:		Days Hours s

CLIENT'S EMERGENCY CONTACT INFORMATION				
Name	Relationship	Phone	Email	Address

CLIENT'S 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	

PARENT OR GUARDIAN INCOME/ENTITLEMENTS AND AMOUNT

Please enter N/A to any questions that do not apply

☐ Check box if information is not available

SSI:	Wages:	VA Benefits:
SSDI:	Rental Assistance:	Other (Specify):
WIC:	Social Security:	Other (Specify):
Food Stamps:	TEMHA(*Temp Emergency Medical & Housing Assis*):	

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VOCATIONAL /EMPLOYMENT INFORMATION Please enter N/A to any questions that do not apply	
Highest Level of Education	**Veteran** ☐ N/A ☐ 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

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	

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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:

CURRENT MENTAL HEALTH OR SUBSTANCE ABUSE TREATMENT/SERVICES (please list **Current** treatment only)			
Outpatient Mental Health Counseling / Psychotherapy: ☐ Yes ☐ No	If Yes, Date of First Counseling Session	Is Client Actively Participating in Counseling? ☐ N/A ☐ Yes ☐ No	
Substance Abuse Treatment: ☐ Yes ☐ No	Date of Admission	Name of Facility	Contact at Facility
	Tentative Discharge Date		Phone
Inpatient Psychiatric Treatment: ☐ Yes ☐ No	Date of Admission	Name of Facility	Contact at Facility
	Tentative Discharge Date		Phone
Residential Treatment Center: ☐ Yes ☐ No	Date of Admission	Name of Facility	Contact at Facility
	Tentative Discharge Date		Phone
Other Treatment: ☐ Yes ☐ No	Date of Admission	Name of Facility	Contact at Facility
	Tentative Discharge Date		Phone

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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 and Telephone	Treatment (List Prescribed Medications in Chart below)
	Med. Professional Phone	
	Med. Professional Phone	
	Med. Professional Phone	
	Med. Professional Phone	
	Med. Professional Phone	
	Med. Professional 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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Enter the Appropriate Diagnoses and ICD-9 and ICD-10 Diagnoses Codes	
DSM-5 Diagnoses	***ICD-9 and ICD-10 Diagnoses Codes***

RECOMMENDATIONS TO CONSIDER IN COLLABORATION WITH CLIENT AND/OR GUARDIAN	
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 both Onsite and Offsite PRP services.	☐ 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

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PRP SKILL BUILDING SERVICES Please check N/A to all questions that do not apply to the client		
Client can benefit from education and support to enhance:		
Symptom Management	☐ N/A ☐ Yes	☐ No
Coping Skills	☐ N/A ☐ Yes	☐ No
Job Readiness	☐ N/A ☐ Yes	☐ No
Relationship & Social Support	☐ N/A ☐ Yes	☐ No
Emotional Resiliency	☐ N/A ☐ Yes	☐ No
Health/Wellness/Safety	☐ N/A ☐ Yes	☐ No
Money Management	☐ N/A ☐ Yes	☐ No
Locating Optimal Housing	☐ N/A ☐ Yes	☐ No
Anger Management	☐ N/A ☐ Yes	☐ No
Accessing Entitlements and Community Resources	☐ N/A ☐ Yes	☐ No
Other	Specify:	
Other Comments:		

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