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***

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CHILD AND ADOLESCENT ADMISSION CRITERIA I have Reviewed the Following Admission Criteria for PRP services:	☐ Yes ☐ No
1. The participant has a PBHS specialty mental health DSM 5 diagnosis, and the participant's impairment(s) and functional behavior can reasonably be expected to be improved or maintained by using these services.	
2. The participant's mental illness is the cause of serious dysfunction in one or more life domains (home, school, community)	
3. The impairment as a result of the participant's mental illness results in:	
a. A clear, current threat to the participant's ability to be maintained in his/her customary setting.	
b. An emerging/pending risk to the safety of the participant and others	
c. Other evidence of significant psychological or social impairments, such as inappropriate social behavior, causing serious problems with peer relationships and/or family members	
4. The participant, due to the dysfunction, is at-risk for requiring a higher level of care, or is returning from a higher level of care.	
5. The participant's condition requires an integrated program of rehabilitation services to develop and restore independent living skills to support the participant's recovery.	
6. The participant 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. .	
7. A documented crisis response plan for the participant is in progress or completed.	
8. An individual rehabilitation plan (IRP) is in progress or completed	
9. PRP services will be rendered by staff that are supervised by a licensed mental health professional	
10. And either:	
a. There is clinical evidence that the current intensity of outpatient treatment will not be sufficient to reduce the participant'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 avert the need to initiate a more intensive level of care due to current risk to the participant or others	
b. For participant 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 avert the need to initiate or continue a more intensive level of care.	

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RECOMMENDATIONS TO CONSIDER IN COLLABORATION WITH CLIENT AND/OR GUARDIAN	
BHLD PRP does not dispense nor oversee management of client medications.	☐ ACCEPTABLE
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

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		☐ 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:	

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CHILD AND ADOLESCENT 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**	
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 or the participant's parent/caretaker must be capable of seeking them as needed.	
Participant's parent/caretaker is capable of seeking support as needed.	
Active involvement of the participant, family, caretakers, or significant others involved in the participant's treatment should 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