

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)	Parent/Guardian Phone:
DOB:	SSN:	Race:
Street Address:		Medical Insurance #
City, State Zip:		Effective Date
Email:		Home Phone:
Partner or Marital Status:		Cell Phone:
Single	Married	Partnered
Divorced	Separated	Widowed
		N/A

REFERRING PROVIDER/AGENCY INFORMATION		
Provider Agency	Name of Provider	
Address of Agency:	Licensure of Provider	
City, State, Zip	Is Provider willing to collaborate with PRP	
Phone:	Fax:	Yes No
Digitally Sign this form on the last page		

REASON FOR REFERRAL TO BHL D'S PRP	
(Check all that apply. Use Other box as needed for reasons not listed)	
Housing	Entitlements
Coping Skills	Relapse Prevention
Relationship/Social Skills	Job Development
Other:	
BHL D PRP may provide a mix of onsite and offsite services depending upon client needs and preferences.	
Could Client benefit from Animal-Assisted Support Services?	Yes No Maybe

CURRENT MENTAL HEALTH TREATMENT/SERVICES			
(please list <u>Current</u> treatment only)			
Outpatient Mental Health Counseling / Psychotherapy:		Is Client an active participant?	
Yes	No	Yes	No

PRIORITY POPULATION DIAGNOSES AND ADMITTING CRITERIA	
Enter the Appropriate Diagnoses and ICD-9 Diagnoses Codes	
DSM-5 Diagnoses	ICD-9 Diagnoses Codes

FUNCTIONAL LIMITATIONS		
Client needs support in some of the areas below to function in the community.	Yes	No
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		

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

Use this space to address the client's medical concerns, other information, or comments:
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Signature of Licensed Mental Health Professional and Credentials	Date
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