InnerSourced Solutions

Behavioral Health and Rehabilitation Services

Adult Psychiatric Rehabilitation Program Referral Form

Date: Referring Agency/Address:

Therapist / Psychiatrist/ PMHNP Name: Licensure Level:

Phone: Fax: Email:

ONCE THIS FORM HAS BEEN COMPLETED AND SIGNED, EMAIL TO: admin2@innersourcedsolutions.com

Consumer Name: Gender: DOB:

Medical Assistance #: Race:

Address: Zip:

Phone: Email:

1. Is the individual currently enrolled in SSI/SSDI? ☐ Yes ☐ No ☐ Unknown
2. Is the individual eligible for full funding Developmental Disabilities Administration services? ☐ Yes ☐ No
3. Is the primary reason for the individual's impairment due to an organic process or syndrome, intellectual disability, a neurodevelopmental disorder, or neurocognitive disorder? ☐ Yes ☐ No
4. Behavioral Diagnosis (Please use the current DSM V, ICD-10 diagnoses) Date:

   Diagnosis given by: Date:
5. Is the individual on medication? ☐ Yes ☐ No

   If yes, list medication associated with diagnosis (Medication name, dosage, and frequency):

   If no, explain why not:

6. Has the individual been found not competent to stand trial or not criminally responsible and is receiving services recommended by a Maryland Department of Health Education? ☐ Yes ☐ No

7. Is the individual in a Maryland State psychiatric facility with a length of stay of more than 3 months who requires RRP upon discharge? (Select No. if an individual is eligible for Developmental Disability Services?) ☐ Yes ☐ No

8. Does this person receive remuneration in any form from the PRP? ☐ Yes ☐ No

9. Duration of current episode of treatment provided to this individual:

☐ Less than one month ☐ 2-3months ☐ 4-6months ☐ 7-12 months ☐ More than 12 months

10. Current frequency of treatment provided to this individual:

☐ At least 1x/week ☐ At least 1x/2 weeks ☐ At least 1x/month ☐ At least 1x/3 months ☐ At least 1x/6 month

11. Has this individual received PRP services from another PRP service within the past year? ☐ Yes ☐ No

If yes, list where:

_____

12. Why is ongoing outpatient treatment not sufficient to address the individuals concerns?

13. Is the individual employed? ☐ Yes ☐ No

If no, does the individual wish to be employed? ☐ Yes ☐ No

14. Has the individual been referred to Supported Employment? ☐ Yes ☐ No

If no, explain why the individual has not been referred to Supported Employment:

_____

_____

_____

_____

_____

☐ Mobile Treatment/Assertive Community Treatment (ACT)

☐ Residential Crisis

☐ Partial Hospitalization Program (IOP)Level 2.2

☐ Residential SUD Treatment Service Level 3.5

☐ Mental Health Intensive Outpatient Program (IOP)

☐ SUD Intensive Outpatient Program (IOP)Level 2.1

☐ Inpatient Psychiatric Treatment

☐ SUD Intensive Outpatient Program (IOP)Level 2.SUD

☐ Residential SUD Treatment Service Level 3.3

☐ Residential SUD Treatment Service Level 3.7

☐ Mental Health Partial Hospital Program

FUNCTIONAL CRITERIA *(Per medical necessity, please provide clinical evidence (examples, frequency, duration) for AT LEAST 3 that apply for the following):* 1. Employment, 2. Daily Living Activities, 3. Social Skills, 4. Completing Tasks, 5. Self-Care, 6. Organization/Planning, and 7. Finances/Resource Acquisition

Example: Client diagnosed with Major Depressive Disorder, recurrent severe, without psychotic features (F33.2)

EMPLOYMENT SAMPLE - The client is currently unemployed and has struggles to find competitive employment. She has a history of working off and on over the past year, as her depressed mood contributes to a marked inability to maintain employment. The client experiences extreme depressive episodes and has challenges with showing up to work on time or at all. Some of her other symptoms include lack of motivation, irritability, sleep disturbance, and difficulty maintaining focus. These symptoms collectively pose a difficulty to carry out the tasks associated with her job description. The client also reports having two verbal altercations with coworkers at her last job.

Presenting Issues:

DURATION OF IMPAIRMENTS:

☐ Marked functional impairment has been present for less than 2years.

☐ Marked functional impairment has been limited to less than 3 of the above listed areas.

☐ Has demonstrated marked impairment functioning primarily due to mental illness in at least three of the areas listed above at least 1-2years.

☐ Has demonstrated impaired role functioning primarily due to a mental illness for at least 3 years

ALTERNATIVE SERVICE AND TRANSITION CONSIDERATION:

Have peer supports and other informal supports such as family been tried? ☐ Yes ☐ No

If yes, why have they been insufficient:

If no, what is the reason this has not been tried:

Has group therapy been tied? ☐ Yes ☐ No

If no, what is the reason this has not been tried:

Had Targeted Case Management been tried? ☐ Yes ☐ No

If no, what is the reason this has not been tried:

Functional impairments can be safely addressed at the PRP level of care: ☐ Yes ☐ No

If yes, list specific ways in which PRP services are expected to help this individual:

COLLABORATION AGREEMENT

I, _____(Therapist Name and Title), agree to participate in team treatment planning sessions/initial session within two weeks of receipt of the referral and quarterly sessions in person or by phone.

Therapist Signature: _____ Date: _____

For ISS Only

Date Referral Received: _____ Received By: _____

Staff Signature: _____ Date: _____