InnerSourced Solutions

Behavioral Health and Rehabilitation Services

Adolescent Psychiatric Rehabilitation Program Referral Form

Date: Referring Agency/Address:

Licensed, Treating Therapist/ Psychiatrist/ PMHNP 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:

Legal Guardian: Relationship (to minor): Legal Guardian Address (if different from above):

School: Address:

Phone: Grade:

Primary Care Physician: Address:

Phone: Fax:

1. Is the individual eligible for full funding Developmental Disabilities Administration services? ☐ Yes ☐ No
2. Have the family or peer supports been successful in supporting this youth? ☐ Yes ☐ No
   If yes, list successes:
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. Does the youth meet the criteria for a higher level of care than PRP? ☐ Yes ☐ No
5. Will the youth's level of cognitive impairment, current mental status, or developmental level impact their ability to benefit from PRP? ☐ Yes ☐ No

6. Is youth currently in mental health outpatient or inpatient treatment? ☐ Yes ☐ No

7. 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 months

8. In the past three months, how many ER visits has the youth had for psychiatric care?

☐ No visits in the last three months ☐ One visit in the last three months ☐ Two or more visits in the last three months

9. Is the youth transitioning from an inpatient, day hospital or residential treatment setting to a community setting? ☐ Yes ☐ No

10. Does the youth have a Targeted Case Management referral or authorization? ☐ Yes ☐ No

11. Has medication been considered for this youth?

☐ Not considered ☐ Considered and Ruled Out ☐ Initiated and Withdrawn ☐ Ongoing ☐ Other

FUNCTIONAL CRITERIA

Within the past 3 months, the emotional disturbance has resulted in…**Check all that apply and detail clinical evidence below. YOU MUST SELECT AT LEAST 1**. If it does not apply, type "N/A":

☐ Evidence of clear, current threat to the youth's ability to be maintained in their customary setting.

☐ Evidence of emerging risk to the safety of the youth or others.

☐ Evidence of significant psychological or social impairments causing serious problems with peer relationships and/or family members.

What evidence exists to show that the current intensity of outpatient treatment for this individual is insufficient to reduce the youth's symptoms and functional behavioral impairments resulting from mental illness?

_____

_____

_____

How will PRP serve to help this youth get to age-appropriate development, more independent living skills?

_____

_____

_____

Has a crisis plan been completed with family and/or guardian? ☐ Yes ☐ No

Has an individual treatment plan/individual rehabilitation plan been completed? ☐ Yes ☐ No

Behavioral Diagnosis (Please use the current DSM V, ICD-10 diagnoses) Date:

_____ _____

Diagnosis given by: Date:

_____ _____

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: _____