FIRST CHOICE COUNSELING CENTER
PSYCHIATRIC REHABILITATION PROGRAM
ADULT REFERRAL FORM

*****PLEASE INCLUDE ASSESSMENT/EVALUATION WITH FORM*****

Please fax to 410 779 9400 or email to fccc1@hushmail.com

Consumer Name:	**D.O.B:**	
Guardian Name: _____ **Does the Parent/Guardian have legal custody (if minor)? __Yes __No**		
Address:		
City:	**State:**	**Zip:**
Home Phone:	**Cell #**	
Medical Assistance/Medicaid #:		
Is the individual currently receiving SSI/SSDI __Yes__No		
Is the individual eligible for full funding for Developmental Disabilities Administration services __Yes __No		
Is the primary reason for the impairment due to an organic process of syndrome, intellectual disability, a neurodevelopmental disorder or neurocognitive disorder ? __Yes __No		
Has the individual been found not competent to stand trial or not criminally responsible and is receiving services recommended by a Maryland Dept of Health Evaluator ? __Yes __No		
Clinical Information		
Is the participant receiving outpatient mental health services? __Yes__No		
Is the licensed mental health provider enrolled as a provider in the Medicaid program? __Yes__No		
Is the participant on medication? __Yes__No		
If selected, are the medications prescribed for MDD (Major Depressive Disorder) or Bipolar? **Medication Name:**		
Why is ongoing outpatient treatment not sufficient to address concerns?		
Occupational		
Is the participant employed?__Yes__No **Has the participant been referred to supported employment? __Yes__No__N/A**		

FIRST CHOICE COUNSELING CENTER
PSYCHIATRIC REHABILITATION PROGRAM
ADULT REFERRAL FORM

ICD-10 Primary Diagnosis Code	
Diagnosing Clinician and Title	

Duration of current episode of treatment provided to this individual
Two or more visits in the last three months

Current frequency of treatment provided to this individual
At least 1x/week

Functional Criteria (Check all that apply and comment where checked)

To understand what is being requested for each of the functional impairments below, a generalized <u>example</u> of a response is provided here:

1. Symptom of Priority Population diagnosis**: Paranoia**
2. Impairment impacting Functioning**: Paranoia results in being suspicious of others.**
3. Example of impaired function: **Last week he would not get on the bus because he thought the driver was out to get him. He started yelling at the bus driver.**

	Marked inability to establish or maintain competitive employment:

Provide evidence of marked inability to establish or maintain competitive employment:

1) Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning:

2) Describe how, specifically, these symptoms impair the participant's functioning:

3) Provide specific concrete examples of THIS participant's impaired function.:

	Marked inability to perform instrumental activities of daily living (e.g: shopping, meal preparation, laundry, basic housekeeping, medication management, transportation and money management)

Provide evidence of marked inability to establish or maintain competitive employment:

1) Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning:

2) Describe how, specifically, these symptoms impair the participant's functioning:

3) Provide specific concrete examples of THIS participant's impaired function.:

	Marked inability to maintain personal support system

Provide evidence of marked inability to establish or maintain competitive employment:

1) Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning:

2) Describe how, specifically, these symptoms impair the participant's functioning:

3) Provide specific concrete examples of THIS participant's impaired function.:

	Deficiencies of concentration/persistence/pace leading to failure to complete tasks

Provide evidence of marked inability to establish or maintain competitive employment:

1) Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning:

2) Describe how, specifically, these symptoms impair the participant's functioning:

3) Provide specific concrete examples of THIS participant's impaired function.:

	Unable to perform self-care (hygiene, grooming, nutrition, medical care, safety)

Provide evidence of marked inability to establish or maintain competitive employment:
1) Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning:

2) Describe how, specifically, these symptoms impair the participant's functioning:

3) Provide specific concrete examples of THIS participant's impaired function.:

	Marked deficiencies in self direction, shown by inability to plan, initiate, organize and carry out goal directed activities.

Provide evidence of marked inability to establish or maintain competitive employment:

1) Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning:

2) Describe how, specifically, these symptoms impair the participant's functioning:

3) Provide specific concrete examples of THIS participant's impaired function.:

	Marked inability to procure financial assistance to support community living

Provide evidence of marked inability to establish or maintain competitive employment:

1) Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning:

2) Describe how, specifically, these symptoms impair the participant's functioning:

3) Provide specific concrete examples of THIS participant's impaired function.:

FIRST CHOICE COUNSELING CENTER
PSYCHIATRIC REHABILITATION PROGRAM
ADULT REFERRAL FORM

Duration of impairments (check off all that applies)	
☐ Marked functional impairment has been present for less than 2 years	☐ Marked functional impairment has been limited to less than 3 of the above listed areas
☐ Has demonstrated marked impairment functioning primary due to a mental illness in at least three of the areas listed above at least 2 years	☐ Has demonstrated impaired role functioning primarily due to a mental illness for at least 3 years

Has consideration been given to using peer support and other informal support such as family? __Yes__No
List attempts and outcomes of any efforts to serve this individual through less formal means such as peer supports, or family:
Has the participant been judged to be in enough behavioral control to be safe in a rehab program and benefit from the rehab provided?:
List specific ways in which PRP services are expected to help this individual:

Licensed Provider Completing this Application:

Print Name: _____

Signature:_____ Date_____

Supervisor Name: _____

Signature:_____ Date_____