FIRST CHOICE COUNSELING CENTER
PSYCHIATRIC REHABILITATION PROGRAM
REFERRAL FORM

*****PLEASE INCLUDE ASSESSMENT/EVALUATION WITH REFERRAL*****

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

| | | |
|---|---|---|
| **Consumer Name:** | **D.O.B:** | |
| **Guardian Name:** _____<br>**Does the Parent/Guardian have legal custody (if minor)? Yes/ No** | | |
| **Address:** | | |
| **City:** | **State:** | **Zip:** |
| **Home Phone:** | **Cell #** | |
| **Medical Assistance/Medicaid #:** | | |
| **Is the individual eligible for full funding for Developmental Disabilities Administration services?** **Yes No** | | |
| **Have family or peer supports been successful in supporting this youth? Yes No** | | |
| **Is the primary reason for the youth's impairment due to an organic process of syndrome, intellectual disability, a neurodevelopmental disorder or neurocognitive disorder Yes No** | | |
| **Is a documented crisis response plan in progress or completed Yes No** | **Has an individual treatment plan/Individual rehabilitation plan been completed? Yes No** | |

| | |
|---|---|
| **ICD-10 Primary Diagnosis Code** | |
| **Diagnosing Clinician and Title** | |
| **Clinician Agency** | |
| **Current frequency of treatment provided to this individual**<br>At least 1x/week At least 1x/2x weeks At least 1x/month At least 1x/3months At least 1x/6months | |
| **How long has youth been engaged in active, documented outpatient treatment?**<br>Less than one month One visit in the last three months Two or more visits in the last three months | |
| **Is the youth transitioning from an inpatient, day hospital or residential setting to the community setting?** Yes No | |
| **Does the youth have a Target Case Management referral or authorization?** Yes No | |
| **Has medication been considered for this youth?**<br>Not considered Considered and Ruled Out Initiated and Withdrawn Ongoing Other<br>Comments: | |

First Choice Counseling Center
9199 Reisterstown Rd Suite 105B
Owings Mills, MD 21117
410 989-9922 (office) 410 779 9400 (fax)

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**REFERRAL SOURCE**

| | |
|---|---|
| Agency Name: | Contact Person Name: |
| Address: | |
| Phone #: | Fax #: |
| Email Address: | |

| **Criteria for admission (CHECK ALL THAT APPLY AND COMMENT WHERE CHECKED)** | |
|---|---|
| | **A clear, current threat to the individual's ability to be maintained in his/her customary setting** |
| **Provide of evidence of clear, current threat to the youth's ability to be maintained in their customary setting:** | |
| | **An emerging/pending risk to the safety of the individual or others** |
| **Provide evidence of emerging risk to the safety of the youth or others:** | |
| | **Significant psychological or social impairments such as inappropriate social behaviors causing serious problems with peer relationships and/or family members** |
| **Provide 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:** | |
| **How will PRP serve to help this youth get to age appropriate development, more independent functioning and independent living skills:** | |

**Licensed Provider Completing this Application**:

Print Name: _ _____ Signature_____ Date_____

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