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

Client Name:	**D.O.B:**	
Guardian Name: _____ **Does the Parent/Guardian have legal custody (if minor)? Yes/ No**		
Address:		
City:	**State:**	**Zip:**
Home Phone:	**Cell #**	
Email Address	**Was parent/client notified of referral?**	
Medical Assistance/Medicaid #:		
Is the individual eligible for full funding for Developmental Disabilities Administration services? ☐ **Yes** ☐ **No**		
Have family or peer support 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	

Current frequency of treatment provided to this individual
☐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?
☐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?
☐ Not considered ☐ Considered and Ruled Out ☐ Initiated and Withdrawn ☐ Ongoing ☐ Other
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:

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Please either submit referral with a copy of evaluation or complete this section by providing a clinical assessment

Clinical Assessment:

Licensed Provider Completing This Application:

Name: _____

Credentials/Title: _____

NPI #: _____

Signature: _____

Date: _____

Supervisor:

(Required if completed by an LMSW, LGPC or LGMFT)

Supervisor Name: _____

Credentials/Title: _____

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