parker
PSYCHIATRIC SERVICES

PRP REFERRAL FORM

Office: (410) 800-4480

Fax: (410) 962-1045

CONSUMER INFORMATION	
NAME:	D.O.B : / /
MA#:	SSN: - -
DIAGNOSIS (Include F-code and description)	
Axis I:	Description:
Axis II:	Description:
Axis III:	Description:
Axis IV:	Description
GAF Current:	
Highest Past Level	
Referring Agency / Address:	
Referring Provider Name:	
Telephone No.: - -	Fax No.: - -
Email:	
Detailed behaviors or issues that are occurring in the home, school, or community indicating precipitating factors:	
Brief History of consumer's behavioral history (include placement history/hospitalizations, previous services:	

Indicate goals of service and how PRP will be rehabilitative for the consumer Behavior Modification/Coping Skills

Parent/Guardian Information:	
Name:	Relationship:
Address:	Phone No.:
Legal Guardian? Check One: ____ ____Yes ___________No	
Name of legal guardian (if not person above)	
Address of legal guardian:	
Phone No.:	Email:
Please list others involved in clients care:	Relationship:
Name:	Address:
Phone No:	Email:
Identify Treatment Foster Care, Therapeutic Group Home, or facility, if applicable:	
Name of Facility:	Phone# 410 - -
Address:	
Is client on any medication? ___________NO _____Yes If Yes, Please list name and dosage:	

List interventions or programs that are already in place for consumer:	
Consumer's Current Therapist:	
Telephone No.: - -	Fax No.: - -
____ Date: ________________________ Signature of Referring Clinician ____ Date: __________________________ Co-Signer Signature (LCSW-C, LCSW, LGSW, LCPC, CRNP, Ph.D, ARPRN, MD)	