PARKER PSYCHIATRIC SERVICES

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410.777.8710

PROVIDER COLLABORATION FORM

Review Period: _____ **Collaboration Due Date:** _____

Date: _____ **PRP Coordinator:** _____
Client Name: _____ **Current Provider:** _____
D.O.B: _____ **Address:** _____

MA#: _____ **Contact #:** _____

Current Diagnosis:		Updated Diagnosis:	
Axis I		Axis I	
Axis II		Axis II	
Axis III		Axis III	
		Axis IV	
		GAF	

Please indicate all services being provided to the client and the frequency of services.

Service Provided	Frequency of Service Provided

Is the consumer/caregiver compliant with mental health treatment? **Yes** **No**
Is the consumer prescribed medication? **Yes** **No**
If yes, please list: _____

Is the consumer compliant with taking medication? **Yes** **No**

Is the consumer receiving any of the following additional mental health treatment services?
If yes, please indicate the Provider:

Respite Care Services		Involuntary Admission to inpatient Mental Health Facility	
Mental Health Vocational Program (MHVP)		Residential Therapeutic Care	
Therapeutic Behavioral Services		Therapeutic Nursery Program	
Residential Crisis Services		Outpatient Mental Health Treatment/	
Psychiatric Day Treatment		Residential Rehabilitation Program	

Please indicate if you are referring the client for continued PRP service: **[ ] Yes** **[ ] No**

Please provide a Summary of Client's Progress:

_____

_____

_____

Print Name/Title: _____ **Date:** _____

Signature: _____

FOR OFFICE USE ONLY:

Verbal Verification (Verified by): (Name/Title) _____

Email Verification (Attach Email)

Phone: 410-800-4480 **Fax: 410-962-1045**