**PRP REFERRAL FORM**

**Fax Number:**

**443-773-5624**

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|  | | |
| **Client Information** |  | |
| Name: | Date of Birth: Age: | |
| MA#: | Race: | |
| Social Security Number: | Language: | |
| School and Grade: | | |
|  | | |
| Axis I: | Description: | |
| Axis II: | Description: | |
| Axis III: | Description: | |
| Axis IV: | Description: | |
| GAF Current: | | |
| Is client on any medication? \_\_\_\_\_ No \_\_\_\_\_ Yes (please list medication name and dosage) | | |
|  | | |
| Referring Agency / Address: | | |
| Referring Provider Name: | | |
| Telephone Number: | Fax Number: | |
| Email: | | |
|  | | |
| Behaviors and/or issues that are occurring in the home, school and/or community: | | |
| Summary of client’s mental health history (include placements/hospitilizations, previous service, etc): | | |
| Indicate client goals and how PRP can facilitate the work on these goals: | | |
| List other interventions and/or programs that are already in place for client: | | |
|  | | |
| **Parent/Guardian Information :** | |  |
| Name: | | Relationship: |
| Address: | | Telephone Number: |
|  | | |
| Legal Guardian? Check One: \_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_ No | | |
| Name of legal guardian if not person above: | | Relationship: |
| Address: | | Telephone Number: |
| Please list others involved in client’s care | |  |
| Name: | | Relationship: |
| Address: | | Telephone Number: |
| Identify Treatment Foster Care, Therapeutic Group Home, or facility if applicable: | |  |
| Name of Facility: | |  |
| Address: | | |
|  | | |
| Contact person: Telephone Number: | | |
|  | | |
| Client’s Current Therapist: | | |
| Telephone Number: | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Referring Clinician Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Co-Signer Signature Date | Fax Number: | |
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