**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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