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therapeutic services

Psychiatric Rehabilitation Program (PRP) Referral Form

Identifying Information:

Client's Name: _____ **Age:** _____ **Transition Age Youth? Y/N** **D.O.B.** _____

Address: _____

City: _____ **State**: _____ **Zip:** _____

Daytime Number: ( ) _____ **Home/Other**: ( ) _____

Social Security Number: _____

Race: _____ **Ethnicity:** _____ **Marital Status**: _____ **Gender**: _____ **Current Level of Education:** _____

Insurance Type: _____ **Medicaid #:** _____ **Authorized:** YES NO

Does the Parent/Guardian have legal custody of the minor? YES NO N/A

If they are an adult, do they have a legal guardian? YES NO N/A

Minor parent's name and contact information:

Name: _____ **Phone:** _____

If parent does not have custody, please provide custodial information:

Name: _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

*****Please note: Services cannot begin unless proof of custody is provided.*****

Employment Status: _____ **# of Arrests in past 30 days:** _____ **Veteran: YES/NO If so which war?** _____

Referral Information:

Reason for Referral *(Client Needs and Presenting Problem)*

_____

_____

_____

Preferred day/time of appointment: _____

Other Preferences: _____

Suicide Risk: ___ **Danger to Self or Others:** ___ **Urgent/Critical Medical Condition:** ___ **Immediate Threat(s):** _____

Past Psychiatric Admission(s): YES NO N/A **Previous Outpatient Treatment**: YES NO N/A

Current Outpatient Provider: _____ **Phone:** _____

AXIS I _____ **AXIS II** _____ **AXIS III** _____ **AXIS IV** _____

Referral Source Printed Name & Institution (IF APPLICABLE): _____

Referral Source Signature: _____ **Date:** _____

MEDICAL NECESSITY CRITERIA
Psychiatric Rehabilitation Program Services (PRP)

Name of Client _____ **Referring Clinician Signature** _____

Diagnosis _____ **Date** _____

FACTORS OR CRITERIA JUSTIFYING THE NEED FOR PRP SERVICES
(Please check all that apply)

☐

1. The client's mental illness is the cause of serious dysfunction in one or more life domains (home, school, community). Please site examples of dysfunction in one or more life domain.

_____

_____

_____

Based on the clinical evaluation and ongoing treatment plan, PRP services are indicated and are expected to reduce the symptoms of the client's mental illness or the functional behavioral impairment that is a result of the mental illness.

2. The impairment as a result of the client's mental illness results in:

☐ a) A clear, current threat to the individual's ability to be maintained in his or her customary setting, or

☐ b) An emerging/pending risk to the safety of the individual or others, or

☐ c) Other evidences of significant psychological or social impairment

such as inappropriate social behavior causing serious problems with peer relationships and/or family members.

Please site examples of impairments.

_____

_____

☐ 3. The individual, due to dysfunction, is at risk for requiring a higher level of care, or is returning from a higher level of care.

4. Either:

☐ a) There is clinical evidence that the current intensity of outpatient treatment will not be sufficient to reduce the client's symptoms and functional behavioral impairment resulting from the mental illness and restore him or her to an appropriate functional level, or prevent clinical deterioration, or avert the need to initiate a more intensive level of care due to current risk to the individual or others.

Please explain:

_____

_____

Medical Necessity Criteria
Psychiatric Rehabilitation Program Services (PRP)

OR

☐ b) For individuals transitioning from an inpatient, day hospital or residential treatment setting to a community setting there is clinical evidence that PRP services will be necessary to prevent clinical deterioration and support successful transition back to the community, or avert the need to initiate or continue a more intensive level of care. Therapist will make referral to PRP program. The client will be connected with an Outpatient Mental Health Center or mental health provider.

Please explain:_____

_____

_____

☐ 5. The individual's disorder can be expected to improve through medically necessary rehabilitation or there is clinical evidence that this intensity of rehabilitation is needed to maintain the individual's level of functioning; and

☐ 6. The individual is judged to be in enough behavioral control to be safe in the rehabilitation program and benefit from the rehabilitation provided.

PRP SERVICE REQUIREMENTS

☐ 1. Outpatient mental health services and social supports should be identified and available to the individual outside the program hours and the individual or the individual's parent/guardian should be capable of seeking them when needed when the individual is not attending the rehabilitation program.

☐ 2. There is a documented crisis response plan both inside and outside of program hours coordinated with the primary mental health clinician treating the individual that indicates clear responsibility for the mental health clinician and rehabilitation program.