ROOTS
HEALTHCARE SERVICES

PSYCHIATRIC REHABILITATION PROGRAM
PROGRAM REFERRAL FORM
104 Plumtree Rd Belair MD 21015 443-402-1014

REFERRAL SOURCE INFORMATION

Date of Referral: _____ Referring Agency _____

Worker (title and credentials): _____
Phone_____
Fax Number: _____ Email Address: _____

CLIENT INFORMATION

Consumer Name: _____ Gender: _____ Marital Status: _____

SSN: _____ DOB: _____ AGE: _____ RACE: _____

Medical Assistance #: _____ Legal Guardian: _____

Full Address: _____

Phone: _____ Alternate Phone: _____

Primary Care Physician: _____ Phone Number: _____

Employer/School: _____ Grade: _____

Address: _____ Phone:_____

Rehabilitation Services Needed: The individual is in need of program services to enable the individual to improve or restore independent living and social skills necessary to support the individual's:

- ❑ Recovery
- ❑ Coping Skills
- ❑ ADLs
- ❑ Social Skills/Peer Interaction
- ❑ Ability to make informed decisions
- ❑ Difficulty balancing lives struggles
- ❑ Other:
- ❑ Assertiveness/Self-esteem
- ❑ Active substance abuse/use
- ❑ Poor work performance
- ❑ Behavior Interventions
- ❑ Parenting issues
- ❑ Domestic violence concerns
- ❑ Other:
- ❑ Adult Vocational/Educational Skills
- ❑ Difficulty with authority
- ❑ School Performance
- ❑ Learning difficulties
- ❑ Behavioral concerns
- ❑ Other

Reason for Referral/ Presenting Problems
Please provide a detailed description of client behaviors and all treatment presentations (including school concerns):
Please provide details regarding behavioral history (including hospitalizations, out of home placement, previous mental health treatment etc.):   ☐Check box if no previous hospitalizations or treatment history

Current Treatment: Please list the locations, dates, responsible parties and phone numbers of inpatient or outpatient settings in which the consumer currently participates.

1. _____

2. _____

Diagnosis: please indicate current DSM V diagnoses.

ICD 10 Code: _____ DSM V Code: _____

ICD 10 Code: _____ DSM V Code: _____

Diagnosis given by: _____ Date: _____

Medications (Please provide name and dosage amount)

Please forward the most recent assessment and/or treatment plan when sending this referral.

Printed Name and Credentials: _____

Date: _____ **Signature:** _____

When you done filling this form, please email referral to rootshcs@outlook.com