



INTIAL  CONCURRENT

### Referral Form

Office 301-379-6831 | Fax 866-450-1117 | [info@americare1.com](mailto:info@americare1.com)

Name \_\_\_\_\_ D.O.B \_\_\_\_\_ Sex: M F

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ SS# \_\_\_\_\_ MA# \_\_\_\_\_

Has this individual received PRP services from at least one other PRP within the past one year? Yes No if yes, how long ago?

PRP eligibility is restricted to the following ICD-10 diagnoses for Adults (Minors can have any diagnosis). Please check all qualifying diagnoses:

- F20.9: Schizophrenia
- F20.81: Schizophreniform Disorder
- F25.0: Schizoaffective Disorder, Bipolar Type
- F25.1: Schizoaffective Disorder, Depressive Type
- F28: Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
- F29: Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
- F22: Delusional Disorder
- F33.2: Major Depressive Disorder, Recurrent Episode, Severe
- F33.3: Major Depressive Disorder, Recurrent Episode, With Psychotic Features

- F31.13: Bipolar I Disorder, Current or Most Recent Episode Manic, Severe
- F31.2: Bipolar I Disorder, Current or Most Recent Episode Manic, With Psychotic Features
- F31.4: Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe
- F31.5: Bipolar I Disorder, Current or Most Recent Episode Depressed, With Psychotic Features
- F31.0: Bipolar I Disorder, Current or Most Recent Episode Hypomanic
- F31.9: Bipolar I Disorder, Current or Most Recent Episode Hypomanic, Unspecified

- F31.9: Bipolar I Disorder, Current or Most recent episode, Unspecified
- F31.9: Unspecified Bipolar and Related Disorder
- F31.81: Bipolar II Disorder
- F21: Schizotypal Personality Disorder
- F60.3: Borderline Personality Disorder
- IS THE CONSUMER ON MEDICATION  
Yes: [ ] No: [ ] If yes Type of Medication \_\_\_\_\_

	Services Needed
Briefly describe individual's current problems, symptoms and needs for community support. Include any information that you feel will assist in determining eligibility and admission into Advocate's PRP.	Individual needs assistance with: (select all that apply)
	<input type="checkbox"/> Individual Living Skills <input type="checkbox"/> Self-care Skills <input type="checkbox"/> Appointment Management <input type="checkbox"/> Health Promotion & Training <input type="checkbox"/> Cultural Development <input type="checkbox"/> Social Skills <input type="checkbox"/> Financial Hardship <input type="checkbox"/> Behavioral Aides <input type="checkbox"/> Housing <input type="checkbox"/> Crisis Intervention <input type="checkbox"/> Linkage/Accessing Other Services <input type="checkbox"/> Medical/Somatic <input type="checkbox"/> Court Order <input type="checkbox"/> Legal Issues <input type="checkbox"/> DJS Involvement <input type="checkbox"/> DSS Involvement <input type="checkbox"/> Substance Abuse Issues <input type="checkbox"/> School Problems
This individual has a serious mental illness which has required the intervention of the public mental system in the last two years Yes No	

#### REFERRAL SOURCE INFORMATION

Therapist Name / Credentials	Supervisor Name/ Credentials	Phone Number
Agency Name		Fax Number
Address (number, street, suite number, city, state, and ZIP code)		Email

This Individual is hereby referred to receive Psychiatric Rehabilitation Services from Advocate Support Services. If fully implemented it will assist the individual to improve and/or maintain independence and current functional level in the community.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_