Psychiatric **R**ehabilitation **P**rogram (**PRP**)
REFERRAL and RELEASE OF INFORMATION

Name:_____AGE: _____

Date of Birth _____/_____/_____ Grade: _____

School (if applicable) _____

Address: _____APT #: _____

_____

_____
Guardian's Name (if applicable)

Home Phone: (_____) _____-_____

Guardian Cellular: (_____) _____-_____

Guardian Work: (_____) _____-_____

Client Cellular: (_____) _____-_____

Consumer MA: _____

Referring Agency:_____ Name of Agency Contact: _____

Agency Referral Phone: ( ) _____ - _____ Contact Email: _____

Consent to Services:
I understand that I am applying for mental health services for the Psychiatric Rehabilitation Program of the Worcester County Health Department. I agree to receive these services if approved and to participate in the development of a Treatment Plan, which I will be asked to sign. I understand that I may revoke my consent to services at any time by written or verbal request.

Information Release:
I authorize the above referenced referring provider to furnish to the Worcester County Health Department, the information requested on the Psychiatric Rehabilitation Program Pre-screening and the Psychiatric Rehabilitation Program forms for review. This information will be used to make a pre-determination of eligibility for Psychiatric Rehabilitation Program services. As part of pre-determination of eligibility, I further authorize the Worcester County Health Department to contact other agencies from which I might be receiving services. If found eligible for services, I further authorize the release of this information to the Worcester County Health Department's Psychiatric Rehabilitation Program for full screening and service eligibility determination and to Optum, to determine eligibility for Psychiatric Rehabilitation services. I understand that I may revoke my permission at any time by written or verbal request.

Consumer Signature (or guardian):_____ Date: _____

Witness: _____ Date: _____

Psychiatrist's Signature_____ Date: _____
(only needed if active with Psychiatrist):

Clinician's Signature: _____ Date: _____

Date of last clinical evaluation: _____ Diagnosing Clinician: _____, _____
(Please include credentials)

*Referring individual will be required to participate in a phone call with the PRP provider to determine eligibility.

PSYCHIATRIC REHABILITATION PROGRAM
ADOLESCENT PRE-SCREENING (18 AND YOUNGER)

DSM V Diagnosis – Please include the numerical diagnosis and order of priority		
Diagnosis:	Duration:	
	Yes	No
If the client is in school, are they involved in any after school activities, including work, which would interfere with delivery of PRP services 3 times a month?	☐	☐
Is the client's demographic information (phone & address) up-to-date in our electronic system?	☐	☐
Is the client willing to participate in group services?	☐	☐

Other Referral Information:	Yes	No
Is the client eligible for full funding for DDA services?	☐	☐
Have family or peer supports been successful for client?	☐	☐
Is the primary reason for impairment due to the following: organic process or syndrome, intellectual disability, neurodevelopmental or neurocognitive disorder?	☐	☐
Does the client meet criteria for a higher level of care other than PRP?	☐	☐
Will the client's level of cognitive impairment, current mental status, or developmental level impact their ability to benefit from PRP?	☐	☐
Is the client currently in Mental Health Outpatient Treatment?	☐	☐

1. Therapist (include credentials, if LMSW or LGPC include supervisor's info)

   _____
   Name / Credentials

2. Duration of active, documented outpatient treatment for:
   - ☐ At least 1x/week
   - ☐ At least 1x/2weeks
   - ☐ At least 1x/month
   - ☐ At least 1x/3months
   - ☐ At least 1x/6 months

3. Please list any other treating providers, including PCP/MCO:

   PCP: _____
   Name / Credentials / Agency

   _____
   Name / Credentials / Agency

4. Duration of active, documented outpatient treatment:
   - ☐ Less than one month
   - ☐ 1-3 months
   - ☐ 6 months or more

5. In the past 3 months, how many ER visits has the client had for psychiatric care?
   - ☐ No visits in the last 3 months
   - ☐ One visit in the last 3 months
   - ☐ Two+ visits in the last 3 months

6. Is the client transitioning from an inpatient, day hospital, or residential treatment setting to a community setting?
   - ☐ YES
   - ☐ NO

7. Does the client have a Targeted Case Management referral or authorization?
   - ☐ YES
   - ☐ NO

8. Has medication been considered for this youth?
   - ☐ Not considered
   - ☐ Considered and ruled out
   - ☐ Initiated and withdrawn
   - ☐ Ongoing
   - ☐ Other

9. Select one and please explain how the primary mental health diagnosis hinders client's ability to perform or complete selected criteria:

   ☐ A clear, current threat to the client's ability to be maintained in their current setting:

   ☐ An emerging risk to the safety of the client or others:

   ☐ Significant psychological or social impairments causing serious problems with peer relationships and/or family members:

10. Please check all that apply:

☐ The client's condition requires an integrated program of rehabilitation services to develop and return to age appropriate development and progress towards independence.

☐ The client does not require a more intensive level of care and is judged to be in enough behavioral control to be safe in the rehabilitation program and benefit from the rehabilitation required.

☐ The client's disorder can be expected to improve and there is clinical evidence that this intensity of rehabilitation is needed to maintain the individual's level of functioning.

☐ The client, due to dysfunction, is at risk of requiring an out of home, residential placement, or is returning from out of home placement or residential placement.

11. Have family or peer supports been successful for client?

☐ YES (if YES, please explain)
☐ NO

12. Please explain how current therapy for this client is insufficient to reduce the client's symptoms and functional behavioral impairments:

13. EXAMPLE OF ADOLESCENT NARRATIVE:

CLIENT HAS DIFFICULTY INTERACTING WITH PEERS OFTEN RESULTING IN PHYSICAL ALTERCATIONS; IS ANGRY WITH THEIR PARENT AND OFTEN CALLS THEM DEROGATORY NAMES. CLIENT HAS RECEIVED ASSAULT CHARGES DUE TO ALTERCATIONS WITH PARENT. CLIENT IS ON FORMAL PROBATION DUE TO 2 MALICIOUS DESTRUCTION AND ASSAULT CHARGES; HAS A HISTORY OF ALCOHOL AND DRUG USE. PRP WOULD HELP REDUCE EMOTIONAL AND BEHAVIORAL PROBLEMS AT SCHOOL, HOME AND IN THE COMMUNITY. PRP WOULD HELP WITH SAFETY AS IT PERTAINS TO DRUG AND ALCOHOL EDUCATION. CLIENT WOULD BENEFIT FROM POSITIVE SOCIAL SKILLS TRAINING TO IMPROVE RELATIONSHIPS WITH FAMILY AND PEERS. CLIENT LACKS POSITIVE SOCIAL OUTLETS, IS IN NEED OF POSITIVE RECREATION ACTIVITIES TO AVOID FURTHER LEGAL ISSUES AND MAINTAIN THEIR CURRENTLY ENVIRONMENT.

PLEASE INDICATE HOW PRP WILL SERVE TO ASSIST THIS YOUTH: PLEASE WRITE YOUR NARRATIVE HERE:

14. HAS A CRISIS PLAN BEEN COMPLETED WITH FAMILY/GUARDIAN?

- ☐ YES
- ☐ NO

15. HAS AN INDIVIDUAL TREATMENT PLAN BEEN COMPLETED?

- ☐ YES
- ☐ NO

DISABILITY STATUS:	YES	NO	N/A
IS THE CLIENT DEAF OR DO THEY HAVE A SERIOUS DIFFICULTY HEARING?	☐	☐	☐
IS THE CLIENT BLIND OR DO THEY HAVE SERIOUS DIFFICULTY SEEING, EVEN WHEN WEARING GLASSES?	☐	☐	☐
BECAUSE OF A PHYSICAL, MENTAL, OR EMOTIONAL CONDITION, DOES THE CLIENT HAVE SERIOUS DIFFICULTY CONCENTRATING, REMEMBERING, OR MAKING DECISIONS?	☐	☐	☐
)OES THE CLIENT HAVE SERIOUS DIFFICULTY WALKING OR CLIMBING STAIRS (AGE 5 OR OLDER)?	☐	☐	☐
DOES THE CLIENT HAVE DIFFICULTY DRESSING OR BATHING (AGE 5 OR OLDER)?	☐	☐	☐
BECAUSE OF A PHYSICAL, MENTAL OR EMOTIONAL CONDITION, DOES THE CLIENT HAVE DIFFICULTY DOING ERRANDS ALONE SUCH AS VISITING A DOCTOR'S OFFICE OR SHOPPING?	☐	☐	☐

16. EMPLOYMENT STATUS:

- ☐ STUDENT
- ☐ VOLUNTEER
- ☐ EMPLOYED FULL TIME
- ☐ EMPLOYED PART TIME
- ☐ DISABLED

17. TOBACCO USE IN THE PAST 30 DAYS?

- ☐ YES
- ☐ NO

18. DOES CLIENT SMOKE CIGARETTES?

- ☐ YES
- ☐ NO

19. HAS CLIENT PARTICIPATED IN A SELF-HELP GROUP IN THE LAST 30 DAYS?

- ☐ YES (IF YES, NUMBER OF TIMES IN SELF-HELP GROUP IN THE PAST 30 DAYS _____)
- ☐ NO

20. NUMBER OF DEPENDENT CHILDREN: _____

21. PRIMARY SOURCE OF INCOME: _____

22. CLIENT'S BASIC NEEDS ARE BEING MAINTAINED (HOUSING, UTILITIES, ETC.)

- ☐ YES
- ☐ NO

23. PRP WORKER SAFETY:

☐ IS IT RECOMMENDED THAT CLIENT BE SEEN AT THE CLINIC INSTEAD OF HOME DUE TO SAFETY?
IF SELECTED, EXPLAIN:

24. SUBSTANCE ABUSE INFORMATION

IS THERE A HISTORY OF SUBSTANCE ABUSE?

- ☐ YES
- ☐ NO

IS THE CLIENT INVOLVED IN SUBSTANCE ABUSE TREATMENT?

- ☐ YES (IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION)
- ☐ NO

A. PRIMARY SUBSTANCE USED: _____

AGE OF FIRST USE: _____
ROUTE OF ADMINISTRATION: _____
FREQUENCY OF USE: _____
DATE LAST USED: _____

B. SECONDARY SUBSTANCE USED: _____

AGE OF FIRST USE: _____
ROUTE OF ADMINISTRATION: _____
FREQUENCY OF USE: _____
DATE LAST USED: _____