ACIDD
AMERICAN CENTER FOR INTELLECTUAL AND DIVERSE DISORDERS IN MARYLAND

REFERRAL FORM

Individual Name: _____ MA#: _____ SS#: _____ DOB: _____
Address: _____ Phone #_____ Race: _____
I am referring the above individual for the following services: ☐ **PRP in PG County** ☐ **MHVP in PG County**

This form must be filled out in its entirety in order to allow for medical necessity and authorization for services.

Primary Behavioral Diagnoses (DSM-V):_____

Primary Medical Diagnoses:_____

Social Elements Impacting Diagnosis

☐ None	☐ Access to Health Care	☐ Housing Problems	☐ Social Environment
☐ Educational	☐ Legal System/Crime	☐ Occupational	☐ Homelessness
☐ Financial	☐ Primary Support(s)	☐ Other Psychosocial/Environment	☐ Unknown/Other

This individual has a serious mental illness which has required the intervention of the Public Mental Health System in the last two years:
☐ **Yes** ☐ **No** **If yes, when? (dates)** _____

Individual experiences at least three of the following: (check all that apply)
☐ Inability to maintain independent employment
☐ Social behavior that results in interventions by the mental health system
☐ Inability to procure financial assistance due to cognitive disorganization
☐ Severe inability to establish or maintain social supports
☐ Need or assistance with basic living skills
☐ Other (please provide example) _____

Current Medications:_____
Is the individual currently compliant with their medications: ☐ **Yes** ☐ **No**

Presenting symptoms and the frequency/duration of the symptoms: Please include hx of SI and HI

_____

Criminal Hx- ☐ **Yes** ☐ **No**

Reason for Referral: (check all that apply)
1) **Self-care skills:** ☐ Personal hygiene, ☐ Grooming, ☐ Nutrition, ☐ Dietary planning, ☐ Food preparation, ☐ Self administration of medication.
2) **Social Skills:** ☐ Community integration activities, ☐ Developing natural supports, ☐ Developing linkages with and supporting the individual's participation in community activities.
3) **Independent living skills:** ☐ Skills necessary for housing stability, ☐ Community awareness, ☐ Mobility and transportation skills, ☐ Money management, ☐ Accessing available entitlements and resources, ☐ Supporting the individual to obtain and retain employment, ☐ Health promotion and training, ☐ Individual wellness self management and recovery.

_____
Most Recent Psychiatric Hospitalization (location) **Date(s)**

_____
Referring Mental Health Professional Signature and Credentials **Date**

_____ _____
Referring Professionals Name (printed) **Location and Phone Number**

_____ _____
Treating Psychiatrist **Phone** **Treating Therapist** **Phone**

Please email, fax or mail completed the referral form to ACIDD Maryland. (If possible, you should also include the client's diagnostic evaluation and any other relevant documentation when completing the referral.)

300 Thomas Drive, Laurel, MD 21045
Phone: 301-377-0750 Fax: 301-377-0463 Email: info@aciddmaryland.com

Thank you!