REFERRAL FORM

Individual Name: ______________________________ MA#: __________________SS#:__________________ DOB: ______________
Address: ____ Phone #_________________________ Race: __________________
I am referring the above individual for the following services: ☐ **PRP Program** ☐ **Mental Health Vocational Program**

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 history of SI and HI
____
____
Criminal History - ☐ **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 **Credentials** **Treating Therapist** **Credentials**

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.)

8980 Old Annapolis Road, Suite B, Columbia, MD 21045
Phone: 443-319-5010 **Fax: 443-319-5265** **Email:** info@aciddmaryland.com **Thank you!**