Elites Care

CLINICAL REFERRAL FOR PRP

REFERRAL DATE: _____

DEMOGRAPHIC INFORMATION

NAME: _____

ADDRESS: _____

_____

HOME PHONE: _____ Cell Phone: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH : _____

RACE:_____ HISPANIC: ☐Yes ☐No

GENDER: _____ MARITAL STATUS: _____

VETERAN: ☐Yes ☐No If yes, what branch? _____
If you served in a war, please indicate which war?_____

EMPLOYMENT STATUS: ☐Full-Time ☐Part-Time ☐Unemployed ☐Volunteer ☐Sheltered

LEGAL VIOLATIONS (last 30 days): _____

TRANSITION AGE YOUTH (YES/NO)? _____

PARENT/CAREGIVER NAME: _____ PHONE: _____

Does the Parent/Guardian have legal custody of the minor (Yes/No)? _____

If adult, do they have a legal guardian (Yes/No)? _____

If applicable, please list guardian information below:

NAME: _____ PHONE: _____

ADDRESS: _____

_____

Please note that guardianship paperwork must be provided

INSURANCE INFORMATION

Medicaid (Medical Assistance) Number: _____

Other insurance: _____

6495 New Hampshire Avenue Ste. A303 * Hyattsville * Maryland * 20783 * Tel: (240) 825-3153 * Fax: (240) 825-3154
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TREATMENT INFORMATION

Is consumer currently involved in treatment? ***(check all that apply):***

- ☐ Therapy
- ☐ Medication Management
- ☐ Case Management
- ☐ Partial Hospitalization Program
- ☐ Intensive Outpatient Services
- ☐ Substance Use Disorder Services
- ☐ Other: _____

REFERRAL SOURCES

Referring Agency:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Referring Clinician:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Referring Psychiatrist/Psychiatric Nurse Practitioner:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

SERVICES REQUESTED

Reasons for referral (*Please list presenting issues/indicate specific behaviors present*):

_____

_____

_____

_____

_____

_____

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Rehabilitation needs (*please select all that apply*):

☐Independent Living Skills	☐Social Skills/Support Network Building	☐Pre-vocational skills
☐Medication Education	☐Coping/Relapse Prevention Skills	☐Advocacy
☐Benefits	☐Community Resources	☐Health Promotion
☐Financial Planning	☐Community Integration Skills	☐Peer Support
☐Housing	☐Transportation	☐Educational Support

☐Other: _____

As a result of the behaviors indicated above, the consumer experiences disruption in one or more of the following life domains (*please select all that apply*):

☐ Home ☐ School ☐ Community ☐ Work

☐ Consumer's ability to be maintained in his or her customary setting is in jeopardy.
☐ Consumer presents emerging/pending risk to the safety of self or others.
☐ Behaviors are disruptive to peer and/or family relations.
☐ PRP can be expected to reduce symptoms and functional behavioral impairment.
☐ PRP can be expected to prevent clinical deterioration or avert a more intensive level of care.

DIAGNOSTIC INFORMATION

_____ _____
Date of diagnosis: Diagnostician name and credentials

	DIAGNOSIS	**ICD 10 Code**
Primary Behavioral:	_____	_____
Secondary Behavioral:	_____	_____
Primary Medical:	_____	_____
Secondary Medical:	_____	_____
Social Elements:	_____	_____
WHODAS Score:	_____	

I certify that I am the treating provider referring this individual for PRP services.
Please sign with your credentials.

☐Psychiatrist: _____ Date: _____
☐Nurse Practitioner (CRNP-MPH only) _____ Date: _____
☐Licensed Clinician: _____ Date: _____