Positive Steps LLC
5710 Bellona Ave
Suite 102
Baltimore, MD 21212
410-878-6404
Fax: 410-779-9147
www.positivestepsllc.org

Please fax to 410-779-9147

Psychiatric Rehabilitation Program Referral Form

Client Name: _____ **Date of referral:** _____ **Medical Assistance #:** _____
SSN: _____ **Gender:** _____ **Race:** _____
DOB: _____ **Age:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Address: _____
City: _____
State: _____
Zip: _____

Legal Guardian (if applicable): _____
Relationship: _____

Living Situation:

Primary Diagnosis:
Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

Diagnosis given by: _____
Date of diagnosis: _____

Is there documentation to verify this diagnosis? **Yes** ☐ **No** ☐
Is the client currently receiving therapy? **Yes** ☐ **No** ☐

Medications:

Reason for Referral (check all that apply):

☐ Behavior/Conduct Challenges ☐ Emotional ☐ Educational Problems ☐ Employment Instability
☐ Financial Instability ☐ Legal/Incarceration ☐ Medication Mismanagement ☐ Physical/Emotional Abuse
☐ Relational Conflicts ☐ Sexual Abuse ☐ Social/Interpersonal Challenges ☐ Substance Abuse
☐ Suicidal/Homicidal

PRP Services Requested (check all that apply):

☐ Adaptive Resources ☐ Crisis Intervention ☐ Dangerous Behaviors
☐ Education/Vocational Training ☐ Health Promotion ☐ Independent Living Skills
☐ Self-Care Skills ☐ Social Skills
☐ Psychiatric Inpatient/Detention Center Support ☐ Social Relationships & Leisure Activities
☐ Promotion of Wellness, Self-Management, & Recovery

Symptoms and Behaviors/Risk Behaviors (check all that apply):

☐ Anxiety/Panic	☐ Attachment Problems	☐ Depressed	☐ Fire Setting	☐ Homicidal Ideations
☐ Hopeless/Helpless	☐ Hyperactive	☐ Impulsive	☐ Irritable	☐ Isolative
☐ Lying/Manipulative	☐ Manic Mood	☐ Obsession/Compulsion	☐ Oppositional Defiant	☐ Physical Aggression
☐ Property Destruction	☐ Running Away	☐ Self-Care Deficit	☐ Self-Injurious Behavior	☐ Separation Problems
☐ Sexually Inappropriate	☐ Social/Withdrawal	☐ Stealing	☐ Suicidal Ideation	☐ Trauma-related
☐ Truancy	☐ Verbal Aggression			

Referring Therapist (must be a licensed therapist):

Name: _____ **Credentials:** _____ **Email:** _____
Phone: _____ **Fax:** _____ **Agency:** _____
NPI number: _____

Therapist Signature: _____ **Date:** _____

If LMSW or LGPC, please add your supervisor's name and NPI number:

Supervisor Name/Credentials: _____

Supervisor NPI: _____