Community Wellness Foundation LLC

OUTPATIENT MENTAL HEALTH CLINIC/ PSYCHIATRIC REHABILITATION PROGRAM/

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REFERRAL FORM - **Adult**

☐ INTIAL ☐ CONCURRENT TODAY'S DATE

Consumer Name:		**D.O.B:**	**MA#:**	
Parent/Legal Guardian Name:		**Phone Number:**	**Date Requested:**	
Address:				
Emergency Contact Name & Phone #:				
E-Mail Address:				
Race/ Ethnicity:	**Social Security:**	**Gender:**	**Marital Status:**	**Highest Level of Education:**
Employment Status:	**Living Situation:**		**Transition Age Youth: [ ]Yes [ ]No**	
# of Arrests in past 30 days:	**Veteran: [ ]Yes [ ]No**		**Is individual in active mental health treatment?**	

Behavioral Diagnoses- Priority Population Diagnosis- Axis I: _____Axis II-IV:_____

[ ] 295.90/F20.9 Schizophrenia	[ ] 296.53/F31.4 Bipolar I, Most Recent Depressed, Severe
[ ] 295.40/F20.81 Schizophreniform Disorder	[ ] 296.40/F31.0 Bipolar I, Most Recent Hypomanic
[ ] 295.70/F25.1 Schizoaffective Disorder, Depressed type	[ ] 296.7/F31.9 Bipolar I Disorder, Unspecified
[ ] 298.9/F29 Unspecified Schizophrenia Spectrum/Psychotic Disorder	[ ] 296.44/F31.2 Bipolar I, Most Recent Manic, with Psychosis
[ ] 295.70/F25.0 Schizoaffective Disorder, Bipolar Type	[ ] 296.54/F31.5 Bipolar I, Most Recent Depressed, w/o Psychosis
[ ] 298.8/F28 Other Specified Schizophrenia Spectrum/Psychotic Disorder	[ ] 296.40/F31.9 Bipolar I, Most Recent Hypomanic, Unspecified
[ ] 297.1/F22 Delusional Disorder	[ ] 296.89/F31.81 Bipolar II Disorder
[ ] 296.33/F33.2 MDD, Recurrent Episode, Severe	[ ] 301.83/F60.3 Borderline Personality Disorder
[ ] 296.34/F33.3 MDD, Recurrent, With Psychotic Features	[ ] 301.22/F21 Schizotypal Personality Disorder
[ ] 296.43/F31.13 Bipolar I, Most Recent Manic, Severe	[ ] 296.80/F31.9 Unspecified Bipolar Disorder

- Does consumer meet Maryland's Department of Health and Mental Hygiene's Priority Population criteria? Yes____/ No ___

- Is the PPD diagnoses considered to be; severe, chronic and is characterized by impaired role functioning? Yes ____/ No ___

Social Elements Impacting Diagnosis:

ADULT SERVICES ONLY- Check off services for adult referrals					
□ Independent Living Skills	□ Relapse Prevention	□ Adaptive Resources	□ Spiritual	□ Transportation resources/MVA/MTA	□ Hygiene/grooming
□ Medication Management	□ Employment	□ Education/Vocational Training	□ Conflict Resolution	□ Recreation	□ Interpersonal Skills
□ Housing	□ Promotion of Wellness	□ Social Skills -Relationships	□ Age-Appropriate Boundaries	□ Time Management	□ Maintaining personal safety
□ Self-Care Skills	□ Crisis Intervention	□ Entitlements Assistance	□ Academic Achievement	□ Food Resources	□ Psychoeducation
□Money Management	□Anger Management	□Nutrition/Dietary Planning	□ Establish Routine	□Interacting skills with peers/authority	□Take care of belongings

Reason for Referral/ Presenting Issues / Progress Made (Include symptoms, ER visits and other crisis interventions):

PROVIDER/REFERRAL SOURCE INFORMATION

Name of Outpatient Therapist:	**Agency:**	
Address:		
Phone #:	**Fax #:**	**E-Mail Address:**
Licensed Provider Name/Signature/Date		
Clinical Supervisor Name		

Psychosocial Report included? [ ]Yes [ ]No Individualized Treatment Plan (ITP)included? []Yes [ ]No