Dear Mental Health Professional,

Attached is the Referral Form required to receive PRP services from You First Health Systems. The following is required to complete the application process:

- Completed Referral Form
- Medical Records providing a psychosocial and diagnostic summary
- Results of a physical completed within the last year

Please fax the above information to (240) 547-0525. Upon its receipt, I will contact you to schedule an intake appointment. Please feel free to contact me at 301-329-0177 or email info@youfirsthealthsystems.com with any questions. I look forward to working with you.

Sincerely,

You First Health Systems

Intake Coordinator

You First Health Systems

Psychiatric Rehabilitation Program
4325 Forbes Boulevard, Suite E, Lanham, MD 20706
Email: info@youfirsthealthsystems.com
Phone: 301-329-0177
Fax: 240-547-0525

Psychiatric Rehabilitation Program Referral Form

CLIENT INFORMATION:

Client Name:		**Date of Birth:**		Age:	
Street Address:		**Social Security #:**		Sex:	☐Male ☐Female
City, State, Zip:		**Medical Assistance #:**			
Phone #:		**Access to transportation for On Site Activities:**		☐ Yes ☐ No	
Parent/Guardian/ Caregiver Name:		**Relationship:**			
Address (If different)		**Does the Contact Person have Legal custody?**		☐Yes ☐No	
City, State, Zip		**Phone Number:**			

DSM V DIAGNOSIS: (Must have a behavioral diagnosis and be referred by a Licensed MH Professional to be eligible for PRP)

Behavioral Diagnoses: (*Required*)	Diagnosis Code:		Description:			
	Diagnosis Code:		Description:			
	Diagnosis Code		Description:			
Social Elements Impacting Diagnosis: *(Required)*	☐ None ☐Education ☐Financial ☐Access to Health Care ☐Legal System/Crime ☐Primary Support ☐Housing ☐Occupational ☐Social Environment ☐Homelessness ☐*Other Psychosocial & Environmental ☐Unknown *Explain Other Psychosocial & Environment elements:					
Source of Diagnosis:		**Functional Assessment** (*If applicable*)	Measured used:		Score:	

Current Medication (Include dosage and frequency or attached med sheet):		
Risk for Aggressive Behaviors, Suicide, or Homicide (explain):		
Criminal History	☐Yes ☐No If yes, explain:	

REASON FOR REFERRAL: (Indicate the areas you want the PRP to address)

☐ **Self Care Skills** *(Check all that apply)*	☐Personal hygiene/grooming ☐Dressing self ☐ Toileting ☐Nutrition/dietary planning ☐Food preparation ☐Following routines (bed, school) ☐Self administration of meds
☐**Independent Living Skills:** *(Click all that apply)*	☐Taking care of belongings ☐Maintaining living area ☐Safety Skills ☐Money Management ☐Mobility skills ☐Accessing entitlements ☐Skills necessary for housing stability ☐Community awareness ☐Support to obtain and retain employment ☐Health promotion and training ☐Individual wellness self-management and recovery
☐ **Interactive Skills with Others:** *(Click all that apply)*	☐Interactive skills with peers ☐Interactive skills with family ☐Interactive skills with adults
☐ **Leisure/Social Skills:**	☐Community integration activities ☐Participation in activities ☐Developing natural supports
☐ **Anger Management Skills:**	Add info *(if needed):*
☐ **Education:**	Add info *(if needed):*
☐ **Symptom Management:**	Add info *(if needed):*
☐ **Community/Family Resources:**	Add info *(if needed):*
☐ **Other** Explain:	

LICENSCED MENTAL HEALTH PROFESSIONAL PROVDIING REFERAL:

Name & Credentials:		**Agency/Organization :**	
Street Address:		**Phone Number:**	
City, State, Zip:		**E-mail Address:**	
Signature/Date:		**Mental Health Treatment currently being Provided:**	☐Outpatient Mental Health Services ☐Inpatient Mental Health Services ☐Residential Treatment Center

Attach a "Professional Assertion of Need for PRP Services" and a copy of the current Treatment Plan.