###### PRP REFERRAL FORM

###### DATE OF REFERRAL:

FOR OFFICE USE ONLY

**NEW**

**REAUTH**

**CLIENT INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Client’s Name:** | | **DOB:** | **Age:** | |
| **Address:** | | **City:** | **State:** | **Zip:** |
| **Home Phone:** | **Social Security #:** | **Medical Assistance #:**   |  | | --- | | **Email Address:** | | | |
| **Please indicate:** | | | | |
| **Sex: ☐ Male ☐ Female** | **Ethnicity:**  **Religion:** | **Marital Status: ☐ Single ☐ Married ☐ Divorced** | | |

**Client School:**

**Grade:**

**Number of Arrest in last 30 days?**

**LEGAL CUSTODIAN:**

**Are you the birth parent:  Yes  No (If no please present one of the following documents)**

**IMPORTANT: A LEAGAL DOCUMENT MUST BE PRESENTED AT TIME OF INTAKE TO SHOW GUARDIANSHIP:**

**☐ Court ☐ DSS ☐ Notarized letter stating your guardianship with at least one birth parent signature.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name:** | **Relationship:** | **Work Phone:** | **Home Phone:** | |
| **Address:** | | **City:** | **State:** | **Zip:** |

**REFERRAL SOURCE:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Agency:** | **Contact Person:** | | **Therapist Name:** | | |
| **Email Address:** | | **Phone:** | **Ext:** | **Fax:** | |
| **Address:** | | **City:** | | **State:** | **Zip:** |

**PRIMARY CARE PROVIDER:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Facility’s Name:** | | **Doctor’s Name:** | **Phone:** |
| **Address:** | **City:** | **State:** | **Zip code:** |

**DSM-V BEHAVIORAL DIAGNOSIS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DSM-5** | | | | |
| **Behavioral** | | | | |
| Diagnostic Category: | Code: | | Description: | |
| Diagnostic Category: | Code: | | Description: | |
| Diagnostic Category: | Code: | | Description: | |
| **Medical** | | | | |
| Diagnostic Category: | Code: | | Description: | |
| Diagnostic Category: | Code: | | Description: | |
| Diagnostic Category: | Code: | | Description: | |
| **Social elements Impacting Diagnosis (Check all that apply**) | | | | |
| **None** | **Problems with access to healthcare services** | | **Housing problems (not homelessness)** | **Problems related to the social environment** |
| **Education Problems** | **Problems related to interactions with legal system/crime** | | **Occupational problems** | **Homelessness** |
| **Financial problems** | **Problems with primary support groups** | | **Other psychological and environmental problems** | **Unknown** |
| **Functional Assessment** | | | | |
| Date of Diagnosis: | | Assessment Measure/Score: | | |
| Measure: | | Name and Title: | | |

**PRESENTING COMPLAINT:**

**HISTORY OF PRESENTING PROBLEMS:**

Signature/Title Date